

**RECRUITMENT AND RETENTION OF VA MEDICAL
PERSONNEL, BUDGET CONSTRAINTS ON VA
HOSPITAL ADMITTING PRACTICES AND OMB
CIRCULAR A-76**

**HEARING
BEFORE THE
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
NINETY-SEVENTH CONGRESS
FIRST SESSION**

OCTOBER 30, 1981

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(III)

PHYSICIAN RECRUITMENT AND RETENTION WITHIN THE VA MEDICAL CENTERS

FRIDAY, OCTOBER 30, 1981

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 2 p.m., in courtroom No. 1, Tuscaloosa County Courthouse, Tuscaloosa, Ala., Hon. G. V. (Sonny) Montgomery presiding.

Present: Representatives Montgomery, Shelby, Smith, Stump, Gramm, and Byron.

OPENING STATEMENT OF HON. G. V. (SONNY) MONTGOMERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. MONTGOMERY. This hearing will come to order. I am Congressman Sonny Montgomery from the State of Mississippi and chairman of the House Committee on Veterans' Affairs. This is a special field hearing of the Subcommittee on Oversight and Investigations and is being held at the request of the gentleman from Alabama, Mr. Richard Shelby who is the Congressman from this district. Dick is an outstanding member of the Committee on Veterans' Affairs and has the interests of American veterans at heart. He has participated in the many hearings we have held this year and helped get our legislation through the House.

It's a great privilege for us to be in Tuscaloosa today. This is the largest number of committee members that we have ever had at any field hearing and is indicative of the high regard my colleagues and I have for Mr. Shelby. We are also pleased with the very fine turnout we see here this afternoon. Of course, I feel right at home because my home is only about an hour and a half away from here in Meridian, Miss.

These hearings are very important to us and I encourage the witnesses to tell us what they feel so we can go back and make better legislative decisions.

At this time I would like to turn the chair over to Dick Shelby and ask him to introduce the other members who are here with us today.

STATEMENT OF HON. RICHARD C. SHELBY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. SHELBY. Thank you, Mr. Chairman. I, too, appreciate the turnout this afternoon, and at this time, I wish to recognize the other Members of Congress that are here today.

On my extreme right is Congressman Albert Lee Smith from Birmingham, representing the Sixth District of Alabama. He is a member of the House Budget Committee as well as a member of the Veterans' Affairs Committee.

Immediately in front of me is Congressman Bob Stump from Arizona. He is a member of the Armed Services Committee, the Veterans' Affairs Committee and the Select Committee on Intelligence.

On my left, immediately in front of me, is Congressman Phil Gramm from Texas. He is a member of the Budget Committee, a member of the Energy and Commerce Committee, and a member of the Veterans' Affairs Committee.

To Mr. Gramm's left is Congresswoman Beverly Byron from Maryland. She is a member of the Armed Services Committee, and we are certainly glad to have her here in Tuscaloosa with us today.

I wish to add that Congressman Montgomery, in addition to being chairman of the Veterans' Affairs Committee, is a ranking member of the Armed Services Committee.

It is my pleasure to especially recognize—most of you already know him, but there are some here from outside Tuscaloosa—Mayor Al DuPont of Tuscaloosa. Al, being a disabled veteran, is particularly interested in the issues we will be discussing today.

Also with us is Judge Hardy McCollum, the probate judge of Tuscaloosa County.

At this point I would like to thank everyone again for coming. This afternoon we will receive testimony on the implementation of Public Law 96-330, relating to the recruitment and retention of VA medical personnel, as we are aware of the difficulty that the Veterans' Administration is experiencing in obtaining adequate numbers of physicians and nurses. We are also aware of the fact that over 9,900 VA hospital beds have been closed due to the nursing shortage alone. We will hear what are the effects of the budgetary constraints upon VA hospital admitting practices. All of us are concerned about the adequacy of funds to provide inpatient and outpatient care for all eligible veterans.

I have said it before, and I believe every member of this committee has said it, that America owes a great deal of gratitude to all of the veterans who have kept this country together in war and peace. I believe that the 97th Congress—in spite of the budget cuts occurring—will continue to respond positively to the veterans.

On our first panel of witnesses will be Dr. Robert L. Slaughter, chief of staff, Veterans' Administration Medical Center, Birmingham, Ala.; Mr. Floyd McNair, director, Veterans' Administration Medical Center, Montgomery, Ala.; Bernard Price, director, Veterans' Administration Medical Center, Tuscaloosa, Ala.; Mr. Lawrence Stewart, assistant director, Veterans' Administration Medical Center, Tuskegee, Ala.; and Mr. Roy McGinnis, director, State of Alabama, Department of Veterans' Affairs.

Gentlemen, we are going to admit for the record your written testimony that you have previously submitted. To enable us to move along and facilitate questioning, please summarize your testimony in about 5 minutes.

Dr. Slaughter, would you like to begin?

STATEMENT OF DR. ROBERT L. SLAUGHTER, CHIEF OF STAFF, VETERANS' ADMINISTRATION MEDICAL CENTER, BIRMINGHAM, ALA.

Dr. SLAUGHTER. Mr. Chairman, before I begin my testimony, I would like to point out that we have represented with us today all four of the VA medical centers in the State of Alabama. We have elected to approach the issues to be addressed by assigning one individual to discuss a particular issue.

Mr. SHELBY. That will be fine.

Dr. SLAUGHTER. This will represent the views of the VA District 10.

Mr. SHELBY. Who will be your spokesman?

Dr. SLAUGHTER. I will address the first issue—

Mr. SHELBY. Please proceed.

Dr. SLAUGHTER [continuing]. Which deals with recruitment and retention of medical personnel.

The mission and the goal of the Department of Medicine and Surgery is the delivery of quality, comprehensive health care to eligible veteran recipients.

The secondary goal, which actually complements and contributes to the achievement of the primary goal, is maintenance of effective medical education and medical research programs. Achievement of these goals depends heavily upon the availability of adequate and quality physician staff as well as other health care team members. Recruitment of staff must, therefore, receive appropriate attention and consideration in assuring that the necessary components of the mission accomplishment exist.

When looking at the adequacy of physician and staffing within VA hospitals, factors other than total numbers must be considered. Levels of competency must be considered so that a quality level as well as a quantity level can be established.

Some of these factors include physician education level, foreign versus U.S.-acquired degrees specialty training levels of the individual physicians, board certification, continuing education levels, licensing characteristics, average age, sex, and other demographic characteristics, membership in national and local medical societies, and faculty appointment to medical schools. These characteristics would allow comparison of the quality of physicians within the VA to the quality of physicians in other institutions, as well as the Nation as a whole.

I would offer the following generalization about physicians staffing VA hospitals at this time. A high percentage of VA physicians are board certified, and the majority are U.S. graduates. Unlike other medical personnel, many of the physicians are part time, and they derive the remainder of their salary from medical schools or from private practice. Full-time VA physicians as a group tend to be older than part-time staff physicians, have a lower proportion of board-certified specialists, and a higher proportion of foreign medi-

cal graduates. Psychiatric hospitals have a higher proportion of full-time VA physicians than general medical and surgical hospitals, and there is a lower proportion of board certification and a higher proportion of foreign medical graduates. A high percentage of the part-time VA physicians hold university medical school faculty appointments.

When considering retention and recruitment of physicians, I think most surveys have shown that salary is the most important consideration. VA physicians are employed under title 38, United States Code, and salary levels for physicians are established within this code.

Almost all physicians who are appointed within the VA, those with even minimal qualifications, are appointed at the chief level. The salary range for the chief level is from \$46,685—that is step 1—to \$60,689 in step 10.

There is a ceiling placed on salary so that the basic salary cannot exceed \$50,112.50. Any physician appointed at the chief 4 level or above has exceeded the maximum salary at the time of appointment. In actual practice, any board-certified physician is appointed above the chief 4 level at the time of appointment. This means that there is no opportunity for salary increases at any point in his career within the VA from the day of appointment.

Public Laws 94-123 and 96-330 provided special pay authority for physicians and dentists. These laws were helpful in providing additional salary for physicians. Special pay up to as much as \$22,500 is possible for full-time physicians. The minimum amount of special pay given to any full-time physician is \$13,000. If the full-time physician is board certified, the minimum special pay is \$15,000. We see only a differential of \$7,500 between the lowest paid physician and the major service chief.

I think more consideration must be given to the pay scale for physicians than is given in Public Law 96-330, or we are going to see a significant impact in the near future on the recruitment and retention of physicians.

Another area that I would like to emphasize in order to retain physicians is the maintenance of a professionally appealing environment. The physician must be able to feel that he is able to treat his patient population.

I think in these times of decreasing resources where services are being restricted, and in particular, services being restricted to certain categories of veterans, it is important that the legislative body and management make the decisions of who is eligible and who is not eligible for services. This decision must not be passed to the physician level to ration resources on a case-by-case basis. The professional is taught to consider cases on a case-by-case basis. They do not think in terms of a collective system.

If we are going to maintain an adequate physician staff, the physician staff must have a supportive health care team. This includes nurses, it includes technicians, it includes many other types of health care employees.

It has already been pointed out that you are aware of the critical shortage of nurses that exists in the VA hospital system, and also that there is a shortage of candidates for recruitment into any system. This is beginning to have an impact and will continue to

have an impact on physician retention and recruitment if people are not there to care for the patients as the physician feels they should be cared for.

Other types of health care employees should be included in title 38 of the United States Code. At the present time, only physicians, dentists, nurses, podiatrists, and optometrists are included under title 38. We feel that other health care employees must be included in this area to provide the management flexibility that is needed.

I would say in summary that physician recruitment and retention is not a major problem quantitatively within the VA, but qualitatively we would like to see some improvement.

We emphasize again that if the present trend in decreasing services, particularly to certain groups of veterans, continues, it is extremely important that legislative and management actions be taken to protect the professional from decisions of eligibility for resources on a case-by-case basis.

It is important that recruitment and retention of other health care team members be emphasized as an adjunct to recruitment and retention.

I appreciate the opportunity to make these statements on behalf of the Veterans' Administration.

Mr. SHELBY. Thank you, Dr. Slaughter.

If our next witness will proceed as quickly as he can since time is moving on, it would give the other panels time to testify and also give the members present time to ask questions. Please proceed.

[The prepared statement of Dr. Slaughter appears on p. 43.]

STATEMENT OF FLOYD McNAIR, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, MONTGOMERY, ALA.

Mr. McNAIR. Thank you, Mr. Chairman, Members of Congress. It is a pleasure to appear before you today and speak primarily to the budget constraints and some of the issues that we are concerned with. There are many, many others, but we will point out to you those we are sure should be brought to your attention.

Basically, as you know, we have been operating on fixed resources over the past few years. Efforts have been ongoing throughout every medical center in the system to increase our production, to shorten our length of stay and redistribute resources to medical centers having the greatest need.

The medical district initiated planning processes that we are entering into now are giving help in some of these areas.

Increasing demands for inpatient and outpatient services, compounded by the inflationary rise in costs of providing the services, together with limited resources have dictated that each medical center lean toward conservation of treatment services for our veterans. We feel that increased demands can also be the result of veterans relocating from the Snow Belt to the Sun Belt, and we are experiencing this in Alabama.

Most medical centers in Alabama have experienced demands for outpatient treatment over the past few years that we are not able to meet. Many have exceeded the authorized funding in allocating work loads by considerable numbers. Some of those are pointed out in the written testimony.

Medical centers have also had to absorb the costs of employee health benefits programs. A couple of examples—Tuscaloosa absorbed 62,000 this past year, and it will equate to roughly 82,000 in 1982. These are some of the recurring expenses which drain our resources that would otherwise be made available for veterans' health care.

In an effort to provide health care for as many veterans as possible within our austere budgets, certain painful choices are unavoidable.

At present under the priorities provided by Public Law 94-581, and further defined under title 38 in our VA manual M-1, part 1, we are able to furnish full care to priorities 1 and 3. We are, however, unable to provide care to all veterans falling in priorities 5 and 6. The non-service-connected veteran requiring posthospital care, priority 4, in many instances receives modified care. This is the one in between. We can do some but we can't do all.

The Birmingham Veterans' Administration Medical Center has been providing open heart surgery for veterans through a contract with the University of Alabama in Birmingham. We feel this is one of the best open heart surgery programs in the country, which is borne out by the fact that people come to the Birmingham center from all over the country, not just Alabama.

As a result of the budget situation, Birmingham was basically funded for 200 cases, they ran 218 this past year and were turning cases away. At the present time, they have had to restrict their area of concern to medical district 10, which is Alabama and Mississippi. They cannot go outside beyond that. In the past they have had cases from Maryland and many other States throughout the country.

Additionally, increased costs without adequate funding may force Birmingham to limit the number of NSC cases who will receive radiation cases in 1982. They cannot continue performing their treatment with funding at the present rate.

Tuscaloosa VA Medical Center recently renovated and converted a long-term care psychiatric unit to an intermediate care unit. The additional manpower required by the changed mission of this unit was not identified in the original project submission. Current ceiling in funding is not available at the facility to fully utilize this new renovated unit. Efforts are underway, however, in the local office to remedy this situation. The waiting list of some 54 veterans requiring intermediate care, psychiatric care, is presently being maintained at Tuscaloosa.

Also our Tuscaloosa center closed a 62-bed psychiatric ward, bed ward, due to budgetary restraints and insufficient nurse staffing.

The magnitude of our overall problems in providing optimum care and maintaining staffing in facilities to serve our eligible veterans may be judged by considering we will receive in the vicinity of a 6-percent increase in funding in fiscal year 1982 over fiscal year 1981. Providing there are no further restrictions, this trend has been the case over the past few years when inflation has continuously increased ranging from 11 to 15 percent annually, and in some circles they say it is greater.

One can readily say that the available funding does not offset inflation.

I appreciate the opportunity of speaking to you.

[The prepared statement of Mr. McNair appears on p. 45.]

Mr. SHELBY. Thank you. Are you testifying next, Mr. Price?

STATEMENT OF BARNARD D. PRICE, DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, TUSCALOOSA, ALA.

Mr. PRICE. Yes, sir, we thank you for the opportunity of appearing before you this afternoon and presenting you with the views of the Alabama medical centers on circular A-76 on contracting out.

Circular A-76 is a reality for medical centers today. Twenty-seven discrete activities have been identified for review under this program. If we are eventually required to contract out, what impact will this have on management, on employees, and most importantly on the veteran patients?

A number of questions come to mind. For example, what happens when a VA medical center has contracted out for some essential service, and then the contractor employees go out on strike? This will be highly disruptive to our organization. We feel that any legal prohibition against a strike will be of questionable enforceability against the contracted employees.

What happens when a company does poor workmanship under the contract? We think that the VA medical centers would have to put up with inferior work until that contract expires.

What happens when a contractor submits a short-term undercutting bid, and then we lose our capabilities in-house? The contractor can then come in demanding a much higher price for his services after we have lost our in-house capabilities.

Difficulties with our contractors are only one thing we expect to face. We think we are going to need a whole new layer of people to negotiate contracts, to coordinate the activities and simply make sure that the contractors' employees are getting their job done.

We are currently of the opinion that the quality of care and assurance of delivery should not be entrusted to a private business firm that does not also share the responsibility for and commitment to the mission of the VA.

And it is our opinion that if any of the elements of quality, timeliness and control are diminished in any respect, that our responsibility for our VA patients is compromised.

Another factor, special emphasis recruitment programs are going to be directly impacted. This is particularly true in the ones we call our big three. That is our dietetic services, our engineering service, and our building maintenance service. They are most vulnerable under A-76.

A large number of the employees in these services are veterans. They were hired under various veterans' preference programs, and it seems ironic to hire them under those programs and then dismiss them under OMB Circular A-76. We have been experiencing a growing fear among most of our employees since A-76's implementation. They fear for their jobs, they fear for the impact upon patient care.

We in management also have concerns. We have limited or virtually no experience in dealing with contracting out of complete services. Consequently we are concerned about this area. The veter-

an patient, of course, is our primary concern, what impact might they experience?

Consider just one example: Let us assume that food service delivery is compromised. The potential interruption to patient care, I feel, would be very evident. The patient's attitudes which affect his rate of recovery is impacted by the absence of the very essential by which we are concerned.

Another consideration in this exercise is cost. To comply, we must carry out very extensive reviews. This requires countless man-hours. Man-hours are only one part of it. We have concerns about the ability of our staff to carry out this complex task. They lack expertise and experience and, of course, there is the possibility of errors or omissions.

Many of the factors to be applied in these reviews are judgmental in nature and, consequently, they are subject to appeal by the prospective contractors. The problem is further compounded by the possibility of faulty technical specifications. These are the statements of work. Consequently, what you may wind up with is costly contract change orders.

I would like to point out that the VA medical centers are already buying commercial and industrial services from the private sector. For example, window washing, pest control, ambulance services, patient transportation and equipment, and maintenance repair.

These illustrations are indicative of the VA's general reliance on the private sector, as specified in OMB Circular A-76. We feel that this trend will continue, A-76 notwithstanding, provided it is deemed beneficial from both a management standpoint and an economic perspective. We feel that the judgment as to which services are to be provided in-house should be based upon considerations other than just cost.

We are aware that the House and Senate have both passed the Veterans' Disability Compensation, Housing and Memorial Benefits Act of 1981, and that this bill is now law. Section 601 of that law proscribes the use of funds appropriated for medical care, for conducting A-76 cost comparison studies. Hopefully this law is going to give us the necessary temporary relief to consider carefully the total impact of OMB Circular A-76 on the health care system.

However, we firmly believe that permanent redress from the requirements of this circular is warranted for all the reasons that I have presented here today. We strongly urge your support toward that objective.

Again we thank you for the opportunity to present our viewpoints on A-76. And we will be happy to answer any questions you may have.

Mr. SHELBY. Thank you, Mr. Price.

[The prepared statement of Mr. Price appears on p. 46.]

Mr. SHELBY. Mr. Stewart?

Mr. STEWART. Thank you. I do not have a prepared statement, but I would be happy to answer any questions.

Mr. SHELBY. Mr. McGinnis.

**STATEMENT OF ROY C. MCGINNIS, DIRECTOR, STATE OF
ALABAMA DEPARTMENT OF VETERANS' AFFAIRS**

Mr. MCGINNIS. Mr. Chairman and members of the committee, I appreciate the honor of being able to testify before such a distinguished panel.

As director of the Alabama State Department of Veterans' Affairs, I represent some 422,000 living veterans and their dependents in this State. In addition, our department is accredited to represent the State organizations of the American Legion, AMVETS, Veterans of World War I, Inc., and the Military Order of the Purple Heart.

It would be foolish of me to try to leave the impression with you that I have knowledge of all the technical aspects of the ins and outs of the subjects of this hearing. So, rather than my testimony reflecting technical expertise on the subject, it reflects observations and opinions from an environment outside the VA system. In other words, it comes from the day-to-day operation of my office coming in contact with veterans using VA facilities, mixing with members of veterans' organizations, and so forth.

RECRUITMENT AND RETENTION OF MEDICAL PERSONNEL

We think that the health care personnel provisions in Public Law 96-330 should relieve some aspects of this problem throughout the VA system, if nothing were allowed to interfere with its implementation.

As I understand it, the current shortage of physicians and other personnel in the system is due to ongoing budget constraints. As for full-time VA physicians, we don't believe that the bonus provision of Public Law 96-330 will result in a substantial increase in their numbers. Even with a maximum bonus applied, the most a full-time physician can make is around \$73,000. With many physicians outside the VA making \$100,000 to \$200,000, it is easy to see why many full-time VA slots will not be filled.

So, despite the beneficial provisions of Public Law 96-330, it appears there will continue to be a critical shortage of full-time physicians throughout the VA system.

An example close at hand is the fact that an overwhelming majority of physicians at the Birmingham center, including the chief of staff, are part-time status. However, VA centers like Birmingham that are affiliated with medical schools and where there is a large group of highly qualified physicians in all specialties, we think that part-time status actually enhances the quality of medical care.

But we do have reservations about the propriety of the chief of staff working part time with the medical school and part time with the VA. The reason being that there is always a doubt if the veteran's clinical interest is properly represented in an administrative arrangement between the medical school and the VA. This doubt persists regardless of the integrity of the chief of staff.

Please note this observation is certainly not to reflect on any one person.

Otherwise notwithstanding, part-time VA physicians can greatly enhance the quality of medical care. However, we believe that part-

time physicians generally do not take the time with patients or have the understanding of veterans as do full-time physicians.

EFFECTS OF BUDGETARY CONSTRAINTS ON HOSPITAL ADMITTING PRACTICES

As you know, there are four VA hospitals in Alabama. Following are some examples of how their admitting practices have been affected by budgetary restraints.

Three of these hospitals inform me they have no waiting list for veterans with absolute need for hospitalization. However, the hospital at Tuscaloosa informed me that they have a waiting list of entry for non-service-connected veterans for admittance to their intermediate care unit. This is a new unit, and because of lack of funding for staffing, it is not operative. They also tell me that a 62-bed psychiatric ward was recently closed because of lack of funds.

As far as the outpatient treatment for non-service-connected veterans, budgetary constraints have just about eliminated this very important benefit. For example, the Birmingham hospital will not schedule or perform on any of these veterans unless they were discharged from the hospital within a period of 1 year. They will also not furnish medicine at VA expense after 30 days after being discharged, even though sometimes the outpatient treatment is needed further. In fact, the way I understand it, outpatient treatment is authorized up to a period of 1 year.

Another example of where budgetary constraints are quoted as a cause was that medical district 10—medical district 10 is made up of four VA hospitals in Alabama and two in Mississippi—tried to force the closing of certain services at the Montgomery VA Medical Center, beginning October 1, 1981. That effort was temporarily stopped, but it is again a prime target for the year 1982.

The Montgomery center has 120,000 veterans in its primary service area, serving 24 Alabama counties and 6 counties in northern Florida. We think that the elimination of the surgical service in this hospital would be a first step in closing the facility. It would be an unnecessary disservice to the veterans using this facility.

Budget constraints have also forced the Birmingham Center to limit their open heart surgery cases to 200 annually for the year 1982, and to restrict them to patients residing in the primary service area of medical district No. 10. In 1981 the Birmingham center had 218 cases from locations all over the country.

As you know, the demands for medical care have been created by the fact that America has been involved in four wars in the century and has created a veteran population in excess of 30 million.

Care for those veterans who will need and seek it is an inevitable cause of the wars in which this Nation has engaged. It is our hope that the Congress representing the people will not forget that fact and stop the budgetary constraints from affecting their care.

IMPACT OF OMB CIRCULAR A-76 ON THE ABILITY OF THE VA'S MEDICAL SERVICES TO PROVIDE QUALITY HEALTH CARE

I know that the subcommittee is aware of the provisions of Public Law 97-66 just enacted, which has effectively stopped the VA from conducting any further studies on the feasibility of con-

tracting out under OMB Circular A-76, unless the Congress makes funds available for that specific purpose.

Due to this fact and due to Hon. G. V. Montgomery's news release in Montgomery, dated October 21, 1981, I see no benefit or reason to take up the committee's time or anyone's in elaborating on this subject. This is especially so since you already have my detailed remarks as to OMB contracting out principles as applied to the VA medical system.

This, therefore, concludes my testimony, and again I thank you for the honor of being here.

[The prepared statement of Mr. McGinnis appears on p. 48.]

Mr. SHELBY. Thank you, Mr. McGinnis.

I would like to ask Mr. Price this: Mr. McNair indicated in his written testimony that at the Tuscaloosa VA Hospital that you recently converted a long-term psychiatric care unit to an intermediate medicine unit, but that due to budget constraints you are unable to operate the new unit; is this true?

Mr. PRICE. That is correct. We also have closed a 62-bed psychiatric ward. We are going to take the staff from that ward—we are going to take part of the staff from our building 33, along with some patients, and consolidate them into this new unit. That still leaves us with a closed psychiatric ward and half of another building unoccupied.

Mr. SHELBY. Mr. Price, do you not have a waiting list of long-term nursing home type patients?

Mr. PRICE. Yes, we do, sir.

Mr. SHELBY. And about how long is that list at present?

Mr. PRICE. I am going to say approximately at least 60 patients.

Mr. SHELBY. How many more beds, in your best judgment, are needed at the Tuscaloosa facility for long-term nursing care?

Mr. PRICE. We could very easily use an additional 60 beds today.

Mr. SHELBY. Mr. Montgomery, as chairman, do you want to address any questions to the panel?

Mr. MONTGOMERY. Yes, I have some questions.

I want to thank the witnesses for their comments. They have raised some very pertinent points.

Briefly, Dr. Slaughter, what about the cooperation between the medical school and the Veterans Hospital?

Dr. SLAUGHTER. I think the cooperation with the University of Alabama in Birmingham, which basically represents the medical school that is affiliated with all four of the Alabama VA medical centers, has been excellent.

In Birmingham a major component of our physician staff consists of part-time employees who serve as faculty members in the remaining part of their employment. The special pay dollar under the provisions of Public Law 96-330, to the part-time VA physician is a zero fringe dollar. We are beginning to see a reluctance of medical school faculty to accept this zero fringe dollar rather than maintain a university salary dollar, which has a significant fringe.

In general, I would say that our affiliation has contributed significantly to the quality of medical care our district.

Mr. MONTGOMERY. Thank you. I have two questions. It's nice to see my good friend, Mr. Floyd McNair, again and to know he's doing so well. Mr. McGinnis mentioned the notice that we sent out

from Washington pertaining to the contracting-out provision in the compensation bill. The bill provides that funds for contracting out studies cannot be taken from the medical appropriation accounts. I'm a little concerned that some people have the impression that we cut back on veterans' funds in this bill. We have not cut back. We have increased the appropriation and the authorizations. However, due to inflation, we have run into the problem of not enough funds for non-service-connected outpatient treatment and we have had to turn away some of these patients or veterans. There has been an increase in funding but inflation is eating the VA up just like it does to us in our personal lives. How about the shortage of nurses in the different hospitals and how many beds have you had to close for this reason? Just a brief answer from each member of the panel, starting with Mr. McNair.

Mr. McNAIR. No problem in recruitment in Montgomery as far as availability, and we closed no beds for that reason.

Mr. MONTGOMERY. OK. Mr. Price?

Mr. PRICE. We currently have four existing vacancies, and as I indicated earlier, we have closed a 62-bed psychiatric ward because of an inadequate number of nursing personnel to carry on safe care in that location.

Mr. STEWART. We have about 30 vacancies right now, but we haven't had to close any beds at this time.

Dr. SLAUGHTER. Birmingham had 20 vacancies as of this morning. We have had a significant recent turnover of nursing staff. Nursing personnel are leaving for other institutions with more flexibility in working hours and fringe benefits.

We have not closed any ward specifically because of nursing staff shortages.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

Mr. SHELBY. Congressman Smith, do you have any questions for the panel?

Mr. SMITH. Yes.

Do any of you on the panel have any information on availability of service contractors in the smaller cities where VA hospitals are located, like Tuskegee or in Tuscaloosa?

Mr. STEWART. I can just point out that we recently had to send out notices for bids for our keypunch activity, and we received three inquiries, one from the west coast, one from the east coast and one from Huntsville, Ala.

There is nothing in Tuskegee that we know of.

Mr. PRICE. We also at Tuscaloosa recently received an inquiry from a national firm, I believe it was Service Master, who is interested in providing us services at such time as A-76 is forced upon us.

Mr. SMITH. Dr. Slaughter, as I have indicated many times, is very much concerned about trying to be as efficient in the use of the money that we have available to help our veterans and to provide services for them. And I get a lot of feedback on the delays that people have when they come to the Birmingham VA Hospital in trying to, one, get an appointment. Sometimes this takes months in order to do that. And sometimes when veterans come in the morning, they have to wait maybe as long as 4, 6, 8, 10 hours—and

they may have a broken bone or something like this—in order to see a doctor.

And this appears to be a real concern in the Birmingham area. Of course, there is a magazine that addressed itself to this with an article which came out about 5 or 6 months ago.

In your testimony you have indicated, as I understand it, that possibly the salary ranges are just not high enough in order to obtain full-time medical staff. And because there are so many part-time medical staff in the Birmingham area who may be on the teaching staff at the University of Alabama Medical School in the morning and they are only available in the afternoon, some delays are encountered in providing medical care for veterans.

I would appreciate any comments you can give us because we get quite a bit of information of veterans who indicate concern and come to us, I guess kind of as a last resort, asking for help.

Dr. SLAUGHTER. The first comment that I would make to this is that the major demand for increases in veteran health care services has been for outpatient medical treatment.

To give an example of this, in 1974 we had some 50,000 outpatient visits in the Birmingham VA Medical Center. In 1979, we had 100,000. We have doubled in outpatient visits in a period of 5 years. We have been able in the last 2 years, through our various programs of trying to control that growth, to increase to only 115,000 visits this past year. We only grew 15,000 visits.

I think management decisions are being made to protect our inpatient specialty services rather than to continue to divert funds from the inpatient activities to support the increasing demand for outpatient activities to the point that our inpatient services would suffer in quality.

We are supporting open heart surgery because we are a referral center there. We did fund 18 cases over what we had budgeted for the year. So I think some of the dissatisfaction with our outpatient area is the result of a concerted effort to try to control growth and preserve what we feel to be specialty-needed inpatient health resources.

Mr. SMITH. Well, If x number of dollars are available to us, we have to face how to allocate those dollars. If more and more people are coming as outpatients, this takes money from the bed patients—money away from bed patient services. The national average, of course, for retention of patients in community hospitals in 1980 was around 7.6 days, where in VA hospitals the average was around 22.6 days. There is a difference in the length of stay.

Is there a way to speed up and to increase the recovery and shorten the time, so that there will be more money available for outpatient treatment?

Dr. SLAUGHTER. I think that definitely is possible. Not only is it possible, but we have demonstrated it is possible.

In 1971 the average length of stay in Birmingham VA Medical Center was 21 days, which is close to the national average that you gave. As of 1981, our average length of stay is 7.8 days, which corresponds very well to the 7.3 figure you gave for non-Federal hospitals. I think you can see that it is possible to decrease length of stay.

However, I would point out the impact this is going to have on the health care system. The workload of a hospital admission is greatest during the first 3 days of the hospital stay. This is the time the most man-hours of work are usually done. This is when most of the X-rays and all other diagnostic work is done. Even though the stay has been shortened, the total amount of work is still the same. During this initial hospital stay the treatment plans are made. And so with any given stay in the hospital, these initial workloads are necessary. A shorter length of stay is not totally the answer.

And as to your comment about the length of time that it takes someone to see a doctor, or for a patient to be examined at the medical center, being as long as an hour or longer, it takes 15-30 minutes to process patient admissions and get them assigned to a bed.

We have about 30 or more people per day admitted into the Birmingham VA Medical Center. A quick calculation indicates that considerable time is needed to process all of those patients and admit them into the hospital. We try to select out those patients who are emergent in terms of immediate need for medical care and hospitalize them more rapidly. However, because of elective admission, we feel that they should be kept in a normal sequence, and because of the workload that takes several hours during the course of a day.

Mr. SMITH. Why in Birmingham is there such a high turnover of physicians?

Dr. SLAUGHTER. We do not have a high turnover of physicians in Birmingham if we exclude house staff. We have a large house staff which is resident physician staff. We have 104 residents working within the Birmingham VA Hospital. We have a rapid turnover by design. These residents are in training status. They have training rotations. These rotations change each month from one service to another as part of their training program. If we look at our physician staff, however, we do not have a rapid turnover.

Mr. SMITH. I have got one further question, gentlemen, and I guess this is addressed to all four of the VA facilities in the State.

The priorities of veterans coming to a hospital, being admitted and having services provided, I know you have five priorities listed, one through five.

No. 1, the service-connected disability; No. 2, veterans with service-connected disability but wanting treatment for something else; No. 3, veterans without service-connected disability; No. 4, those with non-service-connected disabilities; and No. 5, veterans over age 65.

For my own information as a new Member of Congress, how are these treated when they come in as an outpatient or to be admitted as a bed patient?

Mr. McNAIR. They are given priorities to the extent possible in the order that you have them there. With the service-connected man, he has basically what we refer to as a passionate purple card he presents upon arrival. He gets special attention at that point in time. There may be a non-service-connected case sitting out in the audience who arrived ahead of him, but this guy is getting preferential treatment.

Dr. SLAUGHTER. I will comment on that just a little bit further. Preferential treatment cannot be shown once you are locked into a schedule. You have a number of physicians that you can schedule patients to see, and say we schedule 10 percent of these for service-connected and the other 90 percent are for non-service-connected, or any other percentage division. We do not call up non-service-connected veterans and cancel appointments already established if the demand from service-connected reaches the point where that would be necessary.

However, upon entry into the system, with the initial appointment, we do show a priority for the service-connected veteran. On a particular day, a conflict sometimes develops because a service-connected veteran is scheduled later in the day than a non-service-connected veteran. Many times they can't understand why they have to wait until a non-service-connected veteran is seen before they are seen. This is just the way the scheduling process works out, and we do not change the schedule to show a priority.

Mr. SMITH. Thank you, sir.

Mr. SHELBY. Congressman Stump, do you have any questions?

Mr. STUMP. Thank you, Mr. Chairman.

Mr. Price, you mentioned several areas of concern where contracting out under A-76, loss of jobs, experience, probably your ability to provide patient care, of these what would be the most major concern under A-76?

Mr. PRICE. My major concern is, that I as the director, lose control over the provision of service in my facility. I would then have to work with parties who, in my opinion, would not have the same commitment to the goal that I have. We have had some experience, limited as it may be, in dealing with contractors and as a consequence it is very disruptive to our operations. I just feel that I have responsibility for direct patient care, that this is a Federal responsibility and one which VA employees should perform and not the private sector.

Mr. STUMP. How about the loss of your funds through contracting out, is that a factor?

Mr. PRICE. The cost factor is not primary to me—I think the delivery of service is the primary factor.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. CHAIRMAN. Congressman, Phil Gramm of Texas.

Mr. GRAMM. Thank you, Mr. Chairman. I would like to just define a problem, and ask you a couple of questions. Just running through the panel. We were able as a result of the leadership of people like Richard Shelby, to hold the reduction of the veteran's portion of the budget to a low level for any one item in the budget.

We reduced the veterans budget from what is called the current level, which is the amount we would have to spend in any year to comply with existing laws, with existing programs which currently exist by one-sixth or less than 2 percent. By way of comparison, in some areas of the budget were cut by 30 percent.

As you are aware, we are only halfway to our goal of moving toward a balanced budget, a goal that is strongly endorsed by the American people. The President asked for an additional 12-percent cut in discretionary expenditures in fiscal year 1982. He did exclude the delivery of health care services in the Veterans' Adminis-

tration, one of only three areas in the whole budget that was so exempt. But the bottom line is we are going to have to cut more in veterans programs. That is a fact.

Now, I hear people saying that you don't think much of contracting out and maybe that is not a good idea, but the bottom line really gets down to one or two things. No. 1 is that either we are going to have to save money by doing what we are doing more efficiently or we are going to have to deny people services. Now the question is, where do we go in doing that? And so, if I could, and I know it is a tough question but I would like to just start out by asking each of you where in your operations do you think we could save money? Dr. Slaughter?

Dr. SLAUGHTER. I think that there is general data to support the fact that the cost of medical care has been increasing in excess of the inflationary rate for a long time. I think we must accept that, and there is no way that the VA, even in a noncut status, can continue to provide the services that they have provided in the past in the face of the inflationary growth of health care cost. That leaves us with one alternative, we must decrease services. And I don't think we should do this without changing legislative entitlement, so that we do affect a given population's eligibility status. Then the decision is made who gets cut.

Mr. GRAMM. Let me stop you there and ask you a question. One of the changes we made with Public Law 96-330, which became effective October 1, 1979, was to allow the Veterans' Administration to go behind the poverty oath for non-service-connected veterans. I would like to ask each of you what you have done in your facility, or what you see happening in VA to make use of this new tool that we have provided to try and save money.

Dr. SLAUGHTER. Those instructions you have mentioned have not been received at the field station unless they were received this morning. We have gotten instructions for those employees per se that were hospitalized 2 or 3 years ago and were listed on the priority listing and who obviously have Blue Cross-Blue Shield or some other carrier type of insurance. We have received instructions to go ahead and start billing those and seek reimbursement.

Mr. PRICE. Mr. Gramm, I might also make a comment that, not regarding the poverty oath, going behind the oath, what we attempted to do at Tuscaloosa is to pursue every potential third-party reimbursement that we can get access to in order that we can minimize the cost that we are paying out of our own medical care funds.

Mr. GRAMM. Let me ask an additional question. What do you think of the idea of a co-payment for non-service-connected veterans who receive medical care? Basically, I am saying something like if a person is in the hospital 10 days they have a co-payment of \$5 a day or \$50.

Dr. SLAUGHTER. From a physician's standpoint, I would support that.

Mr. McNAIR. Five dollars in some areas of the country might be satisfactory, if you went to \$50 you would, in particularly the rural areas of Mississippi and Alabama, you would have trouble collecting it.

Mr. PRICE. I think as a basic principal that is very sound. If you look to health care plans in the private sector, you will see that where co-insurance exists, the facilities are not unnecessarily utilized.

Mr. STEWART. I agree with Mr. McNair. I believe a uniform co-payment system would present problems in some areas.

Mr. GRAMM. Let me ask you a question about transportation costs and the Federal Government paying transportation costs. Do you believe that it would impose an undue burden if we either eliminated payment of transportation costs or if we put some deductible on it, like \$10?

Mr. PRICE. In my opinion, I do not believe it would create an undue burden. This idea came about initially to not deny a patient in-patient care, but grew from the out-patient program. We strongly feel it is abused in some cases and there is, as you know, a large amount of dollars that are consumed by the program that could be put to much better use in our system.

Mr. GRAMM. Well, Mr. Chairman, let me stop because I don't want to run overtime. I would like to say this, that we obviously have some of the family jewels of the Veterans' Administration in Alabama in terms of our hospital system, and I would just like to ask each of you, in your experience in running a major veterans installation if you have ideas about things that we might do that would enable us to keep the money in place providing services.

I personally would appreciate it if you would drop Sonny Montgomery, the chairman of our committee, a letter outlining your ideas. It is easy for someone like me or the committee to look at these problems, but people working with it every day tend to see problems we don't.

I am not saying that any of these things are easy, but the point is we are down to making hard decisions and the decisions ultimately come down to looking at things like making effective use of going behind the poverty oath or copayment or deletion of transportation cost reimbursement or things of this nature if we are to be able to continue to provide service and if we are going to be able to keep that service at the quality that we think that people that serve this country in time of war deserve. So I certainly would appreciate it if you would share with us the information that you have and the ideas that you have.

Thank you, Mr. Chairman.

Mrs. BYRON. Thank you, Mr. Chairman.

I would like to ask Dr. Slaughter a question. As a member of the Armed Services Committee and involved in compensation, I have spent a great deal of time over the last 3 years addressing the issue that you spoke on extremely well, which is recruitment and retention. And it goes one step farther from the military into the Veterans' Administration. We are dealing with the same block of individuals that have had military service before they became veterans.

And we consistently have had the problem of the salary issue, the facility issue, about upgrading the hospital facilities, about continuing training for the physician. And yet I think the testimony that I heard states that the problem is in the nursing area as opposed to the retention of physicians you find are going in to work

in the VA hospitals, and I am not talking about the ones that are part time with the VA or those that are on a rotating basis that you mentioned.

Dr. SLAUGHTER. I will emphasize again what I tried to emphasize in my original testimony. We must look at the qualitative aspects of physician groups as well as quantitative aspects. I think there are a high number of foreign medical graduates within the full-time VA health physician group. I think there are a number of physicians who turn to the VA as a place of employment when they don't want to work as hard as in private practice, and for a number of reasons. Only through a better pay scale can we avoid this group of physicians.

Mrs. BYRON. Do you find that there are certain shortfalls in one or more specialty areas, one more so than the other?

Dr. SLAUGHTER. Yes. And again this is based upon salary. If you look at the most highly paid specialties in medicine, you find that they are the most difficult to recruit into the VA; that is, orthopedic surgery, anesthesiology, and radiology being the top three.

Mrs. BYRON. I was interested in noting the amount of cardiac surgery you discussed earlier. Usually, we do not attribute this to a VA hospital, but rather to a large medical center.

Dr. SLAUGHTER. Well, the service is actually coming from a large medical center. We do contract for this with the University Medical Center, which is connected to us by a bridge. The patients are evaluated at our hospital for surgery. The morning of surgery they go report for their surgical procedure and 24 hours later they are returned for their post-op care with us.

Mrs. BYRON. Mr. Chairman, may I ask one quick question to Mr. McGinnis.

I think the panel would be disappointed if I didn't pursue this fact. But traditionally, a VA hospital has been addressing the male patient and we are now finding an increase of females in the military and we are going to be finding in the next decade or two an increase in female veterans. Do you find that that imposes any problems as far as your medical care or the structure of your hospital?

Mr. MCGINNIS. Well, I am not in the VA system, of course; I am with the State Department of Veterans' Affairs.

Mrs. BYRON. Well, Veterans' Affairs is going to have to deal with female veterans.

Mr. MCGINNIS. Well, I see no problem. I have had no problem up until now—

Mrs. BYRON. Are you seeing an increase in female veterans?

Mr. MCGINNIS. No.

Mrs. BYRON. I guess I had better go back to Dr. Slaughter.

Dr. SLAUGHTER. We are receiving an increased number of applications from female veterans. As a matter of fact, we did a hysterectomy in the Birmingham VA Hospital yesterday morning.

Mrs. BYRON. Is that your first?

Dr. SLAUGHTER. No, ma'am. We are probably doing now about eight hysterectomies a year. We do have GYN consultants on our staff. The problem that we are running into is the privacy of the female within the hospital system, as it is built. We do not have private rooms or separate bathroom and shower facilities. We tend

toward communal showers, this sort of thing. We have to post a guard on the door while the females take their showers. But we are seeing an increase in demand which is going to cause problems.

Mrs. BYRON. Is this going to continue to increase?

Dr. SLAUGHTER. I think it is going to increase, and we are taking steps to accommodate that.

Mrs. BYRON. Thank you, Mr. Chairman.

Mr. CHAIRMAN. I believe, Mr. Montgomery, you had some questions.

Mr. MONTGOMERY. I will be very brief.

Briefly describe to the subcommittee how a non-service-connected veteran comes in for inpatient treatment who has a private health insurance hospitalization policy, how that is handled by the VA hospital.

Mr. McNAIR. Basically, if a non-service-connected veteran appears applying for hospitalization, he is assumed at the time of his interview by the admissions personnel concerning other benefits that may be available to him. Once he has declared all of these assets in terms of health insurance or other carriers, then we have a formula that was established by the central office.

We use this as a guideline, and if the cost or our estimated cost of his care would be within the range of that carrier, then he is told once more it appears to us that you could afford the cost of hospitalization. The monkey is on his back at that point to say whether or not he can, based on that evaluation and conversation between the two.

If we show that he exceeds this by \$20,000 but he still insists that he cannot pay, we have no alternative except to go ahead and admit him to the system. Subsequent to that, somewhere along the way, under the old system it would be referred to the central office for determination whether or not fraud was involved.

Does that answer your question?

Mr. MONTGOMERY. That answers the question. You take no action under the law if a veteran has a private carrier?

Mr. McNAIR. Not at this point.

Mr. CHAIRMAN. Mr. Price, I believe you wanted to make a statement.

Mr. PRICE. Yes, to Mrs. Byron, about female patients. I did not get an opportunity to show you this area today. We are experiencing a growing number of female patients into our psychiatric unit. In order to address the problem Dr. Slaughter said about privacy, we are developing a 12-bed ward, separate and apart from the male facilities, just to take care of this category of patient.

Mr. CHAIRMAN. I want to thank all of you on the panel for appearing today. We have another panel if you want to stick around, whatever you want to do. We appreciate your coming to Tuscaloosa and giving your testimony. We think it has been very beneficial to the committee.

Mr. SHELBY. Our next panel of witnesses will please come forward. Gentlemen, please summarize your oral testimony. All your written testimony will be submitted as part of the record. If you would briefly summarize your testimony then there will be adequate time for the members to ask questions.

The next panel is composed of Mr. Gordon Shewmake, commander, Alabama Department of Veterans of Foreign Wars; Mr. Frederick Schuler, commander, Department of Alabama, The American Legion; Mr. Lewis McCray, national executive committeeman, The American Legion, has been active in The American Legion on a national scale and in the local community for years; Mr. William R. Wigley, commander, Department of Alabama Disabled American Veterans; Mr. Hollis Bridges, senior vice commander, Disabled American Veterans; and Mr. Roy Mitchell, who is a friend and acquaintance, and also a former commander of the Department of Alabama Disabled American Veterans. Roy is a proven veterans' supporter.

Gentlemen, I welcome you to the panel here today. Please proceed with your testimony, Mr. Shewmake.

**STATEMENT OF GORDEN SHEWMAKE, COMMANDER,
DEPARTMENT OF ALABAMA, VETERANS OF FOREIGN WARS**

Mr. SHEWMAKE. Thank you, Mr. Chairman and members of the subcommittee. We thank you for the privilege of appearing before this distinguished subcommittee to present the views of the State of Alabama, Veterans of Foreign Wars of the United States. My statement is approximately 5 minutes long.

The recruitment and retention of full-time American educated health care personnel is continuing to be an increasing problem, not only in our hospitals at Birmingham, Montgomery, Tuscaloosa and Tuskegee, but throughout the entire VA health care system.

Recently 90 percent of the physicians at the Birmingham Medical Center were part-time physicians, and other staffing deficiencies were numerous and most critical in nursing, laboratory, and radiology services.

One of the provisions of Public Law 96-330, which was overwhelmingly passed by both Houses of the U.S. Congress following the President's veto, authorized the Veterans' Administration health professional scholarship program to provide scholarships to students enrolled in physician and nursing training in exchange for commitment by the students to serve as full-time employees within the Veterans' Administration for a specific period of time. Unfortunately, no funding for this program was included in the Veterans' Administration fiscal year 1981 budget.

When our National Legislative Director testified before the Appropriations Committee of both the U.S. Senate and House of Representatives with respect to the fiscal year 1982 budget, he requested \$12 million to be appropriated for the scholarship program, \$7 million for physicians, and \$5 million for nurses. It is my understanding that as the 1982 appropriation stands at the moment, \$4 million is earmarked to start up the nurses' scholarship program, but no funds are included for physicians.

Mr. Chairman, from my observations and that of our VFW service officer, once a veteran is able to overcome the obstacles to being admitted for care in our VA facilities, the treatment and care provided is professional and of high quality.

However, more and more veterans are being denied treatment, and will never make it to a hospital bed even if ill. And I am not

merely speaking of those with non-service-connected disabilities, but those with service-connected disabilities.

As a direct result of budgetary and personnel constraints, veterans are routinely denied care and referred to community facilities as charity patients. To me this is abhorrent because no honorably discharged veteran who served during a period of war should be denied prompt and competent care by the VA.

Along the same line and highly disturbing to me and to the membership of the VFW and the veterans of this State is a recent statement made by the new Administrator of Veterans' Affairs, Robert P. Nimmo, that under today's budget constraints and the soaring cost of medical care, the VA cannot continue to provide full medical care to all veterans, regardless of eligibility.

Furthermore, we have heard that an annual income of \$15,000 a year would disqualify a veteran from care furnished by the VA, regardless of his or her financial obligations and the seriousness of the illness.

If all of this isn't bad enough, we are now told that the administration has proposed slashing another \$451 million out of the VA budget for 1982, and the bulk of that money, \$269.9 million, will be cut from medical care.

Mr. Chairman, as you know, and as we know, and as our national officers have stated at the highest level within the administration and before various committees of the U.S. Congress, further cuts simply cannot be made in the VA budget without doing irreparable violence to the hospital and medical care system or the benefit programs, or both.

Another highly disturbing concept of the administration is the contracting-out studies required of Veterans' Administration by Office of Management and Budget Circular No. A-76.

Appended to my testimony is an extract of the contracting out studies to be initiated at the Veterans' Administration Medical Centers at Birmingham, Montgomery, Tuscaloosa and Tuskegee, which range from pharmaceutical services to all medical records, food service, and many other functions.¹

It is my understanding that there would be more than 5,000 studies throughout the VA hospital and medical care systems at an estimated cost of \$39.1 million. Furthermore, the administration envisions eliminating as many as 30,000 positions within the VA of which more than 60 percent are now filled by veterans. In other words, contracting-out would effectively circumvent veterans' preference in Federal employment, a benefit the VFW fought long and hard to achieve and retain.

In addition, as pointed out by national representatives in testimony before this very subcommittee in Washington, our field representatives who survey VA hospitals and hold conferences with medical center directors are convinced that the imposition of OMB Circular No. A-76 in areas directly impacting patient care would, literally, be catastrophic to the VA hospital and medical care systems for the following reasons:

¹ See p. 65.

There would be a loss of control by management and service chiefs, where they wouldn't be able to deal directly with employees, but would be required to deal with the contractor.

Many good and reliable and motivated VA employees would be lost. There is no assurance that current VA employees would be engaged by private sector.

It is believed that the team concept used in building management, engineering, and other services of a hospital would no longer be as effective.

The employee-patient relationship would most likely cease to exist.

There is the real possibility of lack of concern and compassion for patients on the part of contracted employees.

A contracted employee would not be available for or under any obligation to perform collateral duties.

Further difficulty would occur in the coordination of various activities between services.

An increase in equipment abuse and possible theft is anticipated.

The deep concern of the VFW with respect to contracting out is reflected in our current resolution No. 622, passed by the voting delegates to our 82d National Convention, and appended to my testimony.¹ Our opposition to contracting out is also embodied in our priority legislative goals.

Mr. Chairman, in recent years medical care for our Nation's veterans has become more and more difficult to obtain due to budgetary and personnel constraints. The number of hospital beds has continued to be reduced, and this pattern simply cannot continue if we are to have a viable health care system and honor the Nation's obligations to those who served honorably in our Armed Forces during periods of war and hostility.

We look to this subcommittee, the full committee, and the Congress of the United States to continue to fully honor the commitment made by George Washington when he stated, "it [benefits] was a part of their hire, it was the price of their blood and of your independency, it is therefore more than a common debt. It is a debt of honor."

In conclusion, permit me to compliment the committee for not having caved in to the administration's attempt to cut the VA budget by \$831 million earlier this year, and we look to you to use every resource at your disposal to defeat the current proposal to further reduce the 1982 VA budget by another \$451 million.

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have.

[The prepared statement of Mr. Shewmake appears on p. 51.]

Mr. SHELBY. Mr. Schuler, are you just appearing or do you have testimony?

Mr. SCHULER. No testimony.

Mr. SHELBY. Mr. Lewis McCray will be our next witness.

¹ See p. 52.

**STATEMENT OF LEWIS E. McCRAY, ALABAMA NATIONAL
EXECUTIVE COMMITTEEMAN, THE AMERICAN LEGION**

Mr. McCRAY. Thank you, Mr. Chairman and members of the committee.

I have submitted a detailed written testimony, and in the interest of time I will summarize those remarks.¹

The subject of OMB Circular A-76 is policies for acquiring commercial or industrial products and services needed by the Government. The American Legion resolution submitted with this statement makes clear the seriousness with which this organization is the possible effects of Circular A-76 on two matters of vital concern. Mainly, jobs for veterans and medical care on a timely basis to the sick and disabled veterans.

The American Legion has no essential quarrel with the stated purposes of Circular A-76 to establish the policies and procedures used to determine whether needed commercial or industrial type work should be done by contracts with private sources or in-house using Government facilities and personnel. Nor do we argue with the statements in the memorandum.

In a Democratic free enterprise economic system, government should not compete with the system. We do not say categorically that there are no governmental functions that should not and could not be contracted out.

We do say that experiences thus far raise serious questions as to whether or not contracting out has saved the Government any appreciable amount of money, whether or not it has improved or even maintained services.

We believe Congress should impose stringent oversight on any and all contracting-out activities undertaken by the executive branch. We believe the executive branch should be required to satisfy conclusively the goals of cost-efficiency and cost-savings achieved by contracting out, and that these considerations should be carefully balanced by Congress with equally desirable goal by providing employment opportunities to the veteran population to which the Government has a special obligation in its economic well-being.

VA has indicated to OMB that it would consider only those activities for contracting out that do not have hands-on care. That is not sufficient delineation of the extent of the VA responsibility for care of patients. The fact is that practically everything that is done for the patient directly or indirectly affects his care and treatment, and can only be considered to be direct responsibility of the VA.

As an example of what we mean, let us consider just two elements of patient care, dietetics and laundry. We understand serious consideration has been given in current VA studies to contracting out of dietetic services in the VA medical centers. The way this would work, as we understand it, is that the VA dietitians would continue to prepare and supervise menus and nutrition diets prescribed by physicians. The food preparation and delivery would be contracted out.

¹ See p. 53.

At first glance, this proposition sounds reasonable, but on closer examination it is not. In the first place, VA dietitians could not assure the quality of food preparation if food workers were not under their operational control. This would affect the quality of food prepared and served to patients.

Second, what if the contractor experiences a strike? What guarantee could be given of the preparation and delivery of food and special diets which is prescribed for the majority of patients in any hospital? It has to be realized that the absence of one meal or one special diet could, in the extreme, cost the life of one very sick patient.

How could the VA ever answer to that eventuality? It certainly would not suffice for OMB to declare they never intended for this to happen. The loss of even one patient under these circumstances would lead to charges that the VA would never be able to defend.

The obvious conclusions to draw from this example is food services of the VA medical center must be seriously considered to be the complete and final responsibility of the medical center and the management and physicians who were treating the patients.

A second example is that of laundry service. Here again, at first glance it might seem reasonable to conclude that laundry services of a medical center could be contracted out. However, clean and sanitized laundry is an essential element of hospital operations. A hospital uses a large quantity of laundry on a day-to-day basis. The availability of that laundry is essential. The absence of clean and sanitized laundry for 1 day would cripple the hospital operation. Absence for several days would cause the hospital to discontinue treating patients. This fact makes it obvious that in order to provide clean and sanitized laundry must be guaranteed—therefore, must be under the complete and final control of the hospital management.

The problem we, The American Legion, have with the concept of contracting out as it applies to the Veterans' Administration is that the possibility of dollar savings to the Government must be placed against the special mission of the VA, not only to provide benefits and services to veterans, but also to be an exemplary Federal employee of those who served the Nation in the Armed Forces.

Gentlemen, in the interest of time, my statement on the other matters that you wish are in there and will be addressed by other members of the panel.

Mr. SHELBY. They will be submitted for the record, without objection.¹ Thank you, Lewis.

Mr. Wigley, please proceed.

**STATEMENT OF WILLIAM R. WIGLEY, COMMANDER,
DEPARTMENT OF ALABAMA, DISABLED AMERICAN VETERANS**

Mr. WIGLEY. Mr. Chairman, the Disabled American Veterans is opposed to the implementation of A-76 requirement, not only on the VA Department of Medicine and Surgery, but also on the VA Department of Veterans' Benefits.

¹ See p. 52.

When one looks at the overall total A-76 process would have on the current Veterans' Administration, it is going to hit the VA right where the most damage can be done.

The OMB Circular A-76 indicates that all areas would be open for private contracting, which would include routine medical examinations. It is estimated by the VA that it will take approximately 3,800 studies or 20 to 30 studies in every medical center to comply with the OMB directive.

The number of man hours it would take to complete the 3,800 studies has been estimated at approximately 1,000 staff years.

The VA does not need to in any way, shape or form foresee the implementation of the A-76 process as a good thing for the VA or indeed for the Disabled American Veterans, whom that agency represents.

As a department commander for the Disabled American Veterans in the State of Alabama, I ask your consideration of all of the statements which I have explained in my statement.

We in the DAV ask that you, as the House Veterans' Affairs Committee, look at this subject in the light in which we see it, and I think that you will indeed find that implementation of such a process would be one of the first steps of deterioration for the Veterans' Administration.

Thank you.

[The prepared statement of Mr. Wigley appears on p. 56.]

Mr. SHELBY. Mr. Bridges?

STATEMENT OF HOLLIS BRIDGES, SENIOR VICE COMMANDER, DISABLED AMERICAN VETERANS

Mr. BRIDGES. Mr. Chairman, I thank you for this opportunity to appear before your committee today to testify in behalf of the members of the Disabled American Veterans.

I also wish to thank you for your compassion in the past and your consideration for the needs of disabled veterans in your deliberations and actions later on.

As I understand it, we are here today to discuss the wartime earned entitlements guaranteed disabled veterans by previous congressional actions, specifically title 38 and title 5. All these services I have heard discussed thus far pertain specifically to medical services and employment of disabled American veterans.

As you know, Mr. Chairman, most disabled veterans depend on the VA health care compensation and employment for ourselves and our families. The stated purpose of OMB Circular A-76 is, and I quote: "to provide detailed instructions for developing a comprehensive valid comparison of the cost estimate of Government or for acquiring a product or service by contract, and providing it with the in-house Government resources."

We do not understand how the VA will choose the alternatives without cost comparison. OMB seems to feel that that is not how you choose it; it's simply to let the contract.

We appreciate the joint efforts of this committee to work with the Armed Services Committee since there is a direct tie-in as we see it between the military recruitment, retention, and VA care.

Also we noted research for defense is exempt from consideration of A-76. We do not understand why VA medical research is not

also exempt. The March 29, 1979 provision of Circular A-76 provided for equitable treatment of all parties. There is no equity, nor is equity a consideration when health care of wartime disabled veterans is being held in abeyance pending contracting awards, fee payment debates, contract stoppage and cost overruns.

We noticed another inequity during February 1981, when studies were being made by some 88 military bases across the country to contract out section 3310 of title 5, United States Code, which are 8-A set-aside civil service jobs: guards, elevator operators, messengers, and custodians.

Those are the custodial functions that may be in the process of being violated by the VA at this time.

Mr. Chairman, these two benefits to the disabled veteran, medical care, set-aside jobs, have been guaranteed by Congress. They must be protected.

Thank you.

Mr. SHELBY. Thank you.

Mr. Mitchell?

STATEMENT OF ROY L. MITCHELL, ADJUTANT, AND FORMER COMMANDER, DEPARTMENT OF ALABAMA, DISABLED AMERICAN VETERANS

Mr. MITCHELL. Thank you, Mr. Chairman.

Mr. Chairman, I am going to delete mine quite a bit. I would like to address this issue of VA health care provided on the terms of the impact of physical restraints that are placed upon the Veterans' Administration medical care system.

As you know, Mr. Chairman, the VA central office reports that nationwide VA staff-to-patient ratios for inpatient care are approximately 2.11 to 1. This figure is about one-half the staffing provided in the private sector.

The 2.11-to-1 ratio represents a goal that the VA central office seeks to achieve, and it's an average of all VA medical facilities, about one-half of the staffing provided for the private sector. The 2.11-to-1 ratio represents a goal that the VA central office seeks to achieve as an average of all VA medical facilities.

Quite frankly, I believe that the severe physical constraint imposed upon the VA is directly responsible for this low staff to patient ratio. I simply cannot understand the rationale behind the VA's policy that mandates personnel reduction accompanied by loss of beds to the system. At least, if beds must be cut, the employees could be redistributed elsewhere in the system to help alleviate shortages.

It would seem wise to me that rather than cut acute health care beds, the VA should be converting them into nursing home care beds to handle the increasing demand for this type of care. To me this would be more prudent than building new nursing home care facilities.

It also seems almost sarcastic to ask, Mr. Chairman, what do you think will happen to VA facilities if the trend to cut personnel and resources is allowed to continue while there's an ever-increasing demand on the system? The fact is, Mr. Chairman, if the VA cannot meet its current workload, what will we do with our rapidly aging veteran population in the next few years?

Mr. Chairman, there are two points I wish to discuss with you which are of great concern to veterans. The first deals with the regulations that the VA has proposed to restrict VA hospital care to non-service-connected veterans who have incomes in excess of \$15,000 per year.

From my perspective, I believe this figure is by far too low, if such a means test is to be applied to VA health care, and it should be set much higher. Any reasonable person should realize that an income of \$15,000 per year is not sufficient to offset the exorbitant cost of private hospitalization.

For example, Mr. Chairman, if a veteran with an annual income of \$15,000 per year is denied admission to a VA hospital but has no private insurance coverage and is subsequently admitted to a private hospital and undergoes surgery for a gastric ulcer, that veteran will undoubtedly have medical expenses in excess of \$3,000.

This veteran will then be subjected to severe financial hardship when you consider the high cost-of-living expenses coupled with the fact that 20 percent or more of his annual income must go toward paying his medical bills.

I ask, Mr. Chairman, is this the way a grateful Nation treats its veterans? Personally, I would hope not.

The other point I wish to address deals with the contracting out of VA services as required by OMB Circular A-76. I believe that contracting out of certain hospital services will result in fragmented and totally ineffective management of VA hospitals and outpatient clinics. But even more importantly, I believe that such contracting out will lead to substantial deterioration of the quality of VA health care provided to veterans.

I would urge this distinguished subcommittee to do everything possible to exempt the VA's Department of Medicine and Surgery from the provisions of OMB Circular A-76.

Mr. Chairman, I do want to express to you that I understand the severe physical restraint that has been placed upon all Federal agencies and departments. However, spending in the area of veterans' programs over the past 5 years has declined in terms of percentage of the Federal budget from a high of 5.1 percent then to 3.5 percent of all spending today.

Additionally, the number of VA medical, surgical, and psychiatric operating beds have been reduced by nearly 11,000 since June 30, 1976. The funds appropriated to the VA have assisted millions of veterans and their families and, in terms of breakthroughs in research, have benefited all Americans.

Still, for many veterans, the VA remains their only source of health care. For others, such as Vietnam veterans, we simply hope that the system will be there when they need it.

That concludes my statement, Mr. Chairman, and I again wish to thank you for giving me this opportunity to express my views on these very important matters.

[The prepared statement of Mr. Mitchell appears on p. 58.]

Mr. SHELBY. Thank you, Mr. Mitchell.

I would like to begin my questioning with Mr. Gordon Shewmake.

Mr. Shewmake, you mentioned that due to budgetary constraints, some service-connected veterans are being denied hospital

treatment at some VA medical centers and are being referred to private hospitals as charity cases.

Has this actually occurred in any Alabama VA hospital and, if so, can you provide the facts to me and the committee in order that this committee can follow up. We are vitally interested in this situation.

Mr. SHEWMAKE. Yes, sir; I certainly will. I don't have those with me today.

Mr. SHELBY. I understand that; that is why we are holding these field hearings. We are concerned, just as you are, about the availability of medical care and the quality of it and what it's going to take to get it. Please furnish that information to us as soon as possible.¹

Mr. Montgomery?

Mr. MONTGOMERY. Thank you, Mr. Chairman. I had the privilege this year to speak at all three conventions of the organizations represented here today—the VFW in Philadelphia, The American Legion in Honolulu, and the DAV in Miami. I must say all the organizations picked very nice places to go. I don't have any questions for the panel, but I do want to comment that the veterans' organizations are really the backbone of the veterans' programs which are funded by the Congress and implemented by the administration. You know, if you don't do your job here in Alabama—if you don't have a strong organization of veterans pushing to protect the veterans and to build up a strong defense, then we won't be able to do as good a job in your behalf in Washington. Grassroots support in necessary.

The administration proposed cut of \$800 million in the VA appropriation was too much. We wouldn't accept that. Veterans' programs are not sacred cows, but neither should they shoulder an unequal burden in our effort to restrain Federal spending, fight inflation, and bring down interest rates. Veterans will take their fair share of cuts and under the Gramm-Latta proposal, coauthored by Phil Gramm who is with us today, instead of cutting veterans' programs by \$800 million, we were able to move it down to about \$400 million and pick the areas for cuts which we thought would impact the least on the majority of veterans. I realize some of you are not very happy that we cut back on burial benefits. But we thought that much better than cutting personnel working in hospitals and cutting back on compensation or pension. We're pretty proud of our record this year. We didn't get everything we wanted, but under the circumstances we fared very well. I'll end with this reminder, we can only be effective if we hear from the people back home, so let us hear from you.

Mr. SHELBY. Thank you, Mr. Montgomery.

Mr. Smith?

Mr. SMITH. Thank you, Mr. Chairman.

I wanted to comment. I appreciate the testimony of the gentlemen here from their organizations and the indications of their concerns and I thank you for coming and giving us your input.

Mr. SHELBY. Mr. Stump?

Mr. STUMP. Thank you, Mr. Chairman.

¹ Not received at time of publication.

I don't have any questions, but I would like to make a statement. Gentlemen, thank you for your testimony, but I think sometimes maybe you don't see it from our side up here. We are faced every day with the problem of cut somebody else; don't cut us, you know. You owe us an obligation, et cetera.

But the facts are if we don't win this battle of the budget, if we don't get inflation under control, the day may be shortly coming that we cannot provide these services that we do owe the veterans of this country.

I think what we are here for today is to ask you for some help, your suggestions; either we've got to have more increased efficiency in some areas or we need some suggestions as to where you think that the cut would be the least harmful.

This committee has demonstrated its reluctance to cut the veterans by our past actions, and I don't think there is any question about what we are going to try to do in the future. But, nevertheless, we need some suggestions as to where we can cut without hurting the veterans or hurting at least as little as possible.

Thank you.

Mr. SHELBY. Mr. Gramm?

Mr. GRAMM. Thank you, Mr. Chairman.

I would like to amplify on what both Chairman Montgomery and then our colleague from Arizona, Mr. Stump, has said.

I would like to begin by saying that the leadership of the three major veterans organizations represented here today was crucial to us in the budget. We faced a very difficult decision; we had to come up with some savings.

And, like any other committee or any other authorizing committee of the Congress, we sat down and came up with our cuts that met the target initially. We didn't pass our burden on to the Budget Committee, which we felt didn't have the knowledge of veterans' programs that we had.

So we set about the difficult task of trying to identify priority areas and we identified as the No. 1 priority the veterans medical system. I think the responsibility of the VFW and The American Legion and the Disabled American Veterans organizations in terms of recognizing that we had to accept some reductions and supporting the decisions we made was critically important.

So I would like to echo what our colleague, Mr. Stump, said, and take it one step further.

I think it is important that our major veteran organizations recognize the difficulties that we do face and that the organizations themselves come forward with responsible alternatives and people who are actually engaged in monitoring and participating in veteran programs know more about those programs than people who aren't. And we need your help in terms of setting priorities.

One aspect that we do not have is the luxury of not having to set priorities. This fall, this spring and next we are going to face the very difficult decision of trying to live within a budget.

We are going to have to hold the overall growth of veteran programs to about 5 to 7 percent a year. Now, in that we provide cost-of-living pay benefits on our veterans' compensation programs, and to the extent that inflation exceeds those targets, we are going to overrun there.

The same thing is invariably going to happen with us trying to provide for all medical care. That means that somewhere we are going to have to come up with the slack.

What I would urge each of your organizations to do is to help us in taking a long, hard look and to be cautious, and I guess from a self-serving kind of perspective, responsible in terms of responding to various alternatives being put forward, and in turn coming forward with alternatives that we can look at, because I think we are into difficult decisions.

I think we can make those decisions responsibly, as we have in the past, and they are not going to go away, and while I believe that we will do better than any other committee in the Congress in protecting our programs, the difficulty is still there.

I think we will do better, basically because we are looking at a payment which has been earned.

There are many people whose programs have grown many times as fast as veterans programs who have never and will never do anything for this country. I think that in no way is there waning support in the Congress for veterans programs to provide services and benefits for people who have sacrificed for the preservation of the country.

But even with that, with the fact that we are clearly going to be at the front of the line in terms of use of Federal money, sacrifice is going to be demanded of us. We are going to have to make it, and we are going to need your help in that I ask that you give your help in getting ideas and your help in communicating to your members that we had to make difficult choices and that we had to set priorities.

Thank you, Mr. Chairman.

Mr. SHELBY. Mrs. Byron?

Mrs. BYRON. Let me take that one step further.

I have a large group of veterans' organizations and veterans in my district in western Maryland. I work very closely with them. I chair a veterans legislative advisory committee in my district, and I depend very heavily upon them to advise me in the problem areas.

One of the things that concerns me is the change and the turn-over in Congress. I think we had 75 or 76 new Members last year.

Congressman Shelby, Congressman Gramm and I came in 3 years ago. We are finding fewer and fewer veterans serving in Congress, and I think it's important that veterans' organizations make sure that those members who do not have strong ties as veterans are aware of the problems confronting veterans. We are beginning to find a higher percentage of Congressmen and Congresswomen with no military service, and I think that is an important factor.

I'm one of those individuals without a military service record, and I am very envious of the State of Alabama for the fact that it has four veterans' hospitals. Maryland had a new one projected for construction and it's one of the things that got lost in the shuffle with the budget constraints, so our hospital and one in New Jersey will not be constructed. I'm very concerned with hospital care for our veterans.

One of the things that interests me is the fact that we have developed a lot of legislation concerning veterans' medical services. One instance is the Privacy Act, which mandates many changes in hospitals as far as patient care is concerned, and getting patients more privacy as far as their facilities are concerned.

Anytime you take a large ward of maybe a 15-bed unit and cut down to a 6-bed unit or an 8-bed unit for privacy, you are losing beds. In the same instance, when you are losing those beds, you are also increasing the staffing problem and the cost per staff of nursing care and orderly care.

So you have x number of dollars and it can be divided up in so many ways. By giving better care with a smaller unit, you are increasing the cost percentage and you are cutting back on the beds. I think that is going to be something that we are going to be facing with an increasing number of veterans in the future.

I know that all three of your organizations are very active in letting their members know their views on the issue, and I hope that will continue in the future.

Thank you, Mr. Chairman.

Mr. SHELBY. Thank you, Mrs. Byron.

I would like to say this. As all of you know who have appeared here, your national officers have good rapport with this committee and the Armed Services Committee. We depend on them a great deal. You should continue to be proud of them. Please keep them going.

On behalf of the committee, I would like to thank all of you for appearing here today. It has been our pleasure.

We have another panel to go. Please continue to work to upgrade and expand the veterans' medical service.

Thank you, gentlemen.

Our next panel consists of Mr. Kenneth D. Goff, senior vice commander, Disabled American Veterans, Chapter 80, Cottondale, Ala., who is also chairman of the Mayor's Committee on the Handicapped of Tuscaloosa, Ala.; Mr. Don Reed, a team leader from the Veterans Center in Birmingham, Ala.; and Mr. Charles E. Pendleton, president, American Federation of Government Employees, Local No. 131.

Gentlemen, please summarize your testimony to allow Members of Congress time to ask you some questions.

We are running behind time. I know Mr. Goff, seated here, as a constituent, as the senior vice commander of the Disabled American Veterans, Chapter 80, Cottondale, Ala., which is in Tuscaloosa County, and as the chairman of the Mayor's Committee on the Handicapped of Tuscaloosa, Ala.

He has been real active in the veterans groups in this area and in the State. He was the first one to ask me after I was elected to Congress to try to hold a Veterans' Committee hearing in Alabama.

Although it has taken about 3 years, under the leadership of Chairman Montgomery we are now able to have the hearing. Kenneth did not believe we would have them but here we are. Kenneth, welcome to the panel today.

Mr. GOFF. Thank you, Mr. Chairman.

STATEMENT OF KENNETH D. GOFF, SENIOR VICE COMMANDER, DISABLED AMERICAN VETERANS, COTTONDALE, ALA., AND CHAIRMAN OF THE MAYOR'S COMMITTEE ON THE HANDICAPPED, TUSCALOOSA, ALA.

Mr. GOFF. Chairman Montgomery, these opinions that I am fixing to give you are not any organization's opinions, they are mine. And I am a veteran. I feel that I should have the right to say what I really think.

In response to your letter dated October 6, 1981, in regard to Public Law 96-330 and Circular A-76, I state the following. A short while ago when a veteran approached the Veterans' Administration for assistance with a service-connected condition, the veteran was treated as if he was a second-class citizen. This was in the era when it wasn't popular to be a veteran. Through laws, and personnel education and training, now when you go to the VA, you are at least treated as a person and not just tolerated as in the past.

At one time a vet had to be 100-percent disabled, total and permanent, to receive all medical care. Now 50 percent and above have this service available on all medical levels. Less than 50 percent receive medication and care for only the service-connected condition and related conditions. Did not the whole man perform to receive the service-connected disability? If he did, why not treat the whole man? Any and all veterans, whether disabled or not, should receive the gratitude of their country for services rendered. I state this to show you I remember when.

If the VA system employs a contract system, that would generate retirement of many employees who will simply not want to leave the VA system, at least 40 percent of the employees locally have 20 years of service. They are just going to retire. Then you will have to hire people to pay them plus the retirement.

The millions of dollars you spent in placing Vietnam veterans in the VA system will be wasted. The Vietnam veterans made up 75.6 percent of certain job classifications such as housekeeping locally. You are increasing help to some Vietnam veterans, and now on the other hand, you are jeopardizing the jobs of these people that you are wanting to help.

The issue is politics and bureaucracy, not money versus patient care, as OMB would like for us all to believe. I hope I never live to see the veterans of this Nation denied any and all rights due them. Where was the war baby or the unborn child when Pearl Harbor was bombed or Iwo was taken, or General Doolittle bombed Tokyo? He was yet unborn or too little to take a hand. Every person under 40 years of age owes his or her life to these men and women. If it were not for the courage and love of freedom in these and all others born after who put their lives and well-being only second to the well-being and all human rights that they had, this country would have ceased to exist as a free country. And these are the veterans that you are talking about denying services to.

What if we have another war? Who will be the fighters to be counted? Not the leaders of our country. No, the poor citizens who will be conscripted. Or will there be some of the bureaucratic leaders who now hold high positions in this Government suddenly get religion or move to a foreign country, as in the Vietnam conflict, and when it is over receive amnesty and return to be placed

in very high levels in our Government? If you must economize, start at the top with all people in the U.S. Government, employees as well as elected, a wage deduction of substantial size, starting with the President and reduce his and all other past presidents' income from the U.S. Treasury to a good living, not as it is now, a lavish sum of more than a hundred poor people on poverty level receive each month.

And only then will I concede we, the veterans, need to tighten our belts, but only at a prorated scale equal to one and all alike.

I would like to bring to your attention in the transition of Presidents, President Reagan put a hold on all memos and directives, and then in the shuffle and fast dealing was the Department of the Treasury, Office of Revenue Sharing, part 51 printed in the Federal Register, on the 1st and 5th of 1981, where it was proponent to the declaration of independents to the handicapped and disabled, bringing we, the handicapped, into the 20th century. Now, it no longer exists.

Now, they are trying to abolish the Architectural and Transportation Compliance Board. Without the free movement in which the VA patient is located, will the VA become an island from which to view the world from and not ever be able to evolve into it?

These are questions. If we have all the money in the world to give and take care of the veterans, that is fine, but if when he gets out here he can't ride a bus because he is in a wheelchair or he can't go up to Mr. Louis McCray's meetings in the Federal Building because there is no elevator in it, then what right do I need all of this money for? You are not giving me money to live and to do. I want to go and be as active as everybody else is. And I can't be without all these things being given to us.

Now, money is fine, services are fine, and I feel that every one of them—the services that we are getting—they are paid for. But there are lots of things that we need that we are not getting, and they are real small. They are not the big things. There is a bunch of little ones, and you are overlooking them looking at the bear that is coming through the back door while somebody steals all your chickens out of the hen house.

Thank you, gentlemen.

[The prepared statement of Mr. Goff appears on p. 59.]

Mr. SHELBY. Kenneth, thank you. You speak from the heart and you speak from experience.

Mr. Don Reed is next. He is a team leader of the vet center in Birmingham, is that right, Mr. Reed?

Mr. REED. Yes, sir, that is right.

STATEMENT OF DON REED, TEAM LEADER, VET CENTER, BIRMINGHAM, ALA.

Mr. REED. It is my pleasure to be here. Also, I would first like to thank you all for Public Law 96-22, which provided vet centers for an awful lot of people that I have worked with over the years. I am primarily here as my testimony was written to address some of those issues.

Mr. SHELBY. Your testimony will be submitted to us and made a part of the record.¹ If you would just briefly summarize your testimony now.

Mr. REED. Fine.

Mr. SHELBY. We appreciate it.

Mr. REED. I shall.

The vet center program was designed for 5 years and we are running into our third year so far of operation. To be quite honest, I don't think we are down the road nearly as far as we need to be. I think some of that is some problems in our own leadership. I think some of it has been because some of the good intended support we have had in the Congress hasn't been fully carried out, but the spirit of the vet center program is being adhered to. I think this is mostly reflected in the lack of fees for services money which were allocated through the committee to build to a greater latitude in providing services for Vietnam era veterans suffering from post traumatic stress disorders, who do not just happen to be within a stone's throw of a vet center.

We are finding in Alabama that in many cases this is a great problem, that somebody calls up in a critical situation—many times they are in jail and from their attorney—we are not able to render services to them at the vet center. We have several cases that are pending about this.

Fees for services will allow vet centers all over the country to be able to provide for a smaller price many of the services that we provide in house and extend them out in the professional community by us going out and training many of these people with some idea of the specifics of most traumatic stress disorders. This has come up particular in the case which was in the Tuscaloosa paper today, concerning Mr. Lewis Lowe, who is a Vietnam veteran and one of my clients in Birmingham. Lewis Lowe, if you read the articles, was acquitted yesterday. The paper said "insanity ruled." That is not right. Post-traumatic stress disorder is not insanity. It points to a problem that we have in being able to make the connection in providing services many times beyond the immediate realm of the vet center, beyond the immediate confines of the service area that we are given.

In looking at this case, it is also our philosophy, at least in Alabama vet centers, that given programs targeted by you people in Congress for us with a limited amount of time, that it is up to us to say. We realize that 5 years is—is not going to serve all the needs of all these people. Therefore, we need to be about getting the State of Alabama also involved in picking up this commitment that the Federal Government is trying to take care of to a certain point. This also can be picked up by the community based organizations. We have traditional organizations who have been here today. We have many young Vietnam veteran organizations more aimed at handling these kind of problems that we are encouraging.

I feel recently that Governor James has signed a proclamation saying that this Veteran's Day in the State of Alabama is a special day of recognition for Vietnam veterans. We are looking forward to his presence and Congressmen from Alabama being there on Veter-

¹ See p. 61.

an's Day to make this a real honor to the Vietnam veterans in the State of Alabama. Also, we are hoping this is the beginning of getting the State involved in providing some of the services that we are now providing at the Federal taxpayer's expense. I think in the case of Lewis Lowe again we are talking about having many court cases come up where suddenly the State is going to have the task of providing post traumatic stress disorder counseling. To my knowledge in the State of Alabama, outside the confines of the vet center program, nobody is trained and qualified to do that. We had to have a psychiatrist from Nashville, Tenn., and a psychologist from Florida come in to assist in the case. It is important that we extend these into the—the base and the fact that States provide help to us and to you in picking up the cost of some of these programs and extending the money, as I said, the fees for services being critical. They were put in the initial funding package. We have never seen them at the vet center program. We desperately need that.

Also I feel that one last point I would like to make is concerning salaries of people in the vet centers. There has been a great disparity because we have outside people in many cases brought in. Quite frankly, after wading through the personnel regulations of the Veterans' Administration, I could have not done my job for 6 months trying to figure out who I was in my job description.

So we need assistance from this committee, in my opinion, in making and bringing those salaries in line because in terms of medical retention, this is a new program that we are going to start losing people out of this program because of the lack of flexibility to be able to provide them adequate pay scales to keep them in there. This is a new field that I feel is very important that you people have opened the door to for us and for America. And I think we need to pursue this by having the best people available as we prefer for all other VA medical facilities.

This concludes my remarks. Thank you.

[The prepared statement of Mr. Reed appears on p. 61.]

Mr. SHELBY: Thank you, Mr. Reed.

Mr. Charles Pendleton is next. He is the president of the American Federation of Government Employees, Local 131, at the VA Hospital in Tuscaloosa and is also a VA employee. Mr. Pendleton, please proceed.

STATEMENT OF CHARLES E. PENDLETON, PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, LOCAL 131, TUSCALOOSA COUNTY, ALA.

Mr. PENDLETON. I, too, would like not to read the statement that I have already given you.

Mr. SHELBY. Sure, it will be submitted as part of the record without objection and will be made a part thereof. If you will summarize your remarks. As you know, we are under time constraints and money constraints.

Mr. PENDLETON. I would like to make one statement. It is my personal belief and I think it is provable that A-76, as it exists, is not and has not ever been meant to save the Government money. It was first put in as a tool to circumvent personnel ceilings in the Federal service. It was nonpolitical, it just became a popular thing

to do to say that we don't need as many Federal employees as we have: It was its only purpose, the Government's own study shows that in cases that are studied, that there is no real cost.

In April of 1981, the General Accounting Office studied 12 major contracts and found substantial deviations in those that would have—in the cost comparison—that would have, if proper comparisons had been adhered to, would have rendered those as being no cost savings in those 12 areas.

We in VA have not been scared of A-76, are not being concerned with it, I should say, because it has never bothered us. Having been active within the union, the Department of Defense fought it for years and years, and it did decrease our defense capabilities. When the contracts are given, the only thing that is contracted out is the job. It is contracted out at either an equal cost or a higher cost than it is costing to do them in-house. The only difference is it goes into some employee's pocket as wages, because they come into an area and they pay substandard wages or the bare minimum wages.

It has been said here that what if contract employees are unionized? As far back as in 1976, the American Federation of Government Employees changed its national constitution to where we not only organize Federal employees, also employees that work for contractors of the Federal Government. Right here in the State of Alabama at Fort Rucker, Ala., the American Federation of Government Employees local at Fort Rucker has under contract those employees for two or three different contracts on that station.

We contract out in the VA here. I have approximately 75 percent of the people in my bargaining unit are paying me dues. These are my people. I have no choice but to follow them into that contract job.

The other thing that the contract does, we know today exactly how many Federal employees are on the Federal payroll. But there is no one in the Office of Management and Budget that can tell you how many people really work for the Federal Government. Contractors and the contract employees are used strictly to hide those people and to make the public think they are getting something that is not there.

The impact on our patient population—I don't think there is any way to measure. I was honored to be one of the locals that was to study the central office's draft of a work study for dietetic services.

The deviations permitted in that thing are 10 percent, and I don't know how you measure 10 percent; 10 percent of the diabetics got a regular diet. You know it is just unthinkable to me that the patients can be—or this amount of deviation from normal can be permitted in contracts, but that is what the thing says.

In our station of the major groups that are to be contracted out, approximately 80 percent of those people who are in those jobs are veterans, a very high percent of them are Vietnam-era veterans, all hired under the Veteran's Readjustment Act.

I believe we have to save money within the Federal Government. I don't believe that we can save it with A-76, where the initial expense of implement into VA is untold millions of dollars.

You people, me or no one else knows how many millions of dollars VA has already spent on it, or how many would have been spent had it not been for the action of this committee.

We need to cut down on waste in the Federal Government, and in some areas, mismanagement. If we do that, we have plenty of money. There is a whistleblower's protection law. That is probably the laughingstock of the Federal Service. My people come to me and say, "if I turn this in, what kind of protection do I get from you under the whistleblowers's protection?" I say, "I'll shake your hand, I'll tell you 'goodbye and good luck'."

I am serious when I am saying that the areas not to cut service in VA programs or other Federal programs—to look at the manner or the way that the money is being spent.

That will conclude my statement. Thank you.

[The prepared statement of Mr. Pendleton appears on p. 63.]

Mr. SHELBY. I do not have any questions, but I do have some comments to make.

First of all, many of you have touched on it, including Charlie and Mr. Goff among others. The contracting-out proposition is very dangerous for several reasons. Although contracting out at first glance appears to be an attractive concept, it does not work out as well when implemented.

I do not believe Congress is interested in cutting back VA employees, I am certainly not. With the average age of the veteran of World War II reaching 60 and with a nursing home waiting list as reflected in the testimony, we need to expand; and I believe that Congress will. I do believe that we need to cut back Government operations in several areas. Charlie, I agree we need to cut out waste, but I do not believe we should contract out essential VA hospital services. It would be a dangerous precedent, and I would be one that would oppose it. Mr. Chairman?

Mr. MONTGOMERY. I agree with you, Dick. This subcommittee and the full Committee on Veterans' Affairs has held hearings on OMB Circular A-76, and we are having one next week to hear from the contractors. I think you should be aware that the VA, under present law, has the authority to contract out now. So I question the necessity for VA to implement Circular A-76 and we are going to take a good, long, hard look at all the ramifications of contracting out. Mr. Goff, I thank you for your stirring testimony. We need more folks like you.

Mr. Reed, this is the first time in all our hearings this year that we've had testimony from a vet center representative. It's very informative to hear from you. During the press conference we held prior to this hearing, we had a question about the person acquitted here-in Tuscaloosa. The press asked us what we were going to do about it and I told them that we had the vet centers and that the committee believes this is one way to tackle the problems of Vietnam veterans. I couldn't and did not get into the judicial aspects of the acquittal, but was I right about the vet centers?

Mr. REED. Yes, sir, we have the vet centers available, as I mentioned, it is a problem for a lot of veterans who are not able to—we are not able to reach out far enough to them. We have over 126,000 Vietnam-era veterans in the State of Alabama, and we have 25,000 of them around Birmingham. And they keep me busy enough that I don't—I have too much to say grace over, but we also have an awful lot of other ones who are sitting out there who literally can't—we can't provide help for.

I am afraid not being able to provide that help would lead to some of the cases like Lewis Lowe, the continuing frustration or anger toward going into post-traumatic stress disorder.

I think it is important to the State of Alabama in looking at this that they say, well, the vet centers can provide the help that they are designed to provide, but the State is going to have to be able to provide help after this. We don't have bars on the vet center, so I think it has a problem.

Mr. MONTGOMERY. Do you have a hard time making these vet centers work? Do you call on these veterans' hospitals for help, and do you refer veterans to these medical centers?

Mr. REED. Yes, sir, we refer. We have quite an extensive referral service within the VA. When it comes to dealing with post-traumatic stress disorder, unless someone is in an area of extremely psychotic or in need of medication, we take care of all the treatment there in the vet center in the group interaction and the 1-on-1 therapy that we do. Because really the only known therapy that is basically effective in dealing with this is being able to go back to the model that we use and get a person back into those experiences successfully, this time hopefully get back out of those experiences with an understanding.

I think again part of the problems we are looking at that are extreme is where a lot of people center very much on the war causing a lot of the post traumatic stress disorders. The war caused a lot of problems, but coming home was the real kick in the head. A lot of very well-meaning people who I think would traditionally support veterans of wars of any kind didn't really know what the situation was with the Vietnam veterans. So today part of that readjustment problem is trying to help bring society in a line with these guys and them in a line with society. So that is what I see as being a great goal that we perform other than therapy in reaching out and touching the community and having them be a part of us. It is working very well until we get into a situation where there is a criminal activity involved. And then we are very, very limited. We are not allowed to go into the prisons.

Mr. SHELBY. Mr. Smith?

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Reed, how many vet centers are there in the State of Alabama?

Mr. REED. We are about to open a new one in Mobile that we have recently had approved. We have hired the major staff people there and have put them through one phase of training. Since then the money has been held up in our program for training. We need help on it.

Mr. SMITH. You didn't answer my question. How many? There are two?

Mr. REED. There are two—there is mine and the one in Mobile, yes, sir.

Mr. SMITH. How do people come to the vet center, how do they come to you? Is it through the VA hospital or is it through medical community, is it through other hospitals that they are referred, you know, physicians—How do you—the people that you are seeing there—in the breakdown of percentage, how do they arrive at your doorstep?

Mr. REED. I will say that over 75 percent of the people that come into a vet center are there from the outreach efforts that we have done through the media primarily. We do accept quite a number of referrals, but most of them—we are also aiming quite a bit at people who traditionally have not gone to the Veterans' Administration or who have had a bad experience with the Veterans' Administration, which in our population of veterans, there are several. Because of the years past, a lack of understanding of what these disorders were, these just weren't angry, hard to deal with people. They had problems.

Mr. SMITH. How many can you adequately handle in 1 year's period?

Mr. REED. At this point we have in 2 years' operation seen right over 1,000 I would say that given the current staff restrictions that we have, that would be—about 500 a year would be a good intake. That would keep us busy for a long time, because the treatment process is so long in dealing with—we are getting stacked up.

Mr. SMITH. How long do you usually—What is the average time you usually see a patient—a veteran?

Mr. REED. Well, there are—that is very difficult to say. If I were to—I would hesitate to give you an average, an average based on the program at this point perhaps, 6 months, but that is incomplete in looking at it, because there are veterans that I and Tom Ashley from Tuscaloosa dealt with down here that we are still dealing with 5, 6, and 7 years later. It is very difficult to put a finger on what you do for posttraumatic stress disorders in terms of time, because many of these guys when we see them is the first time they have ever talked about the trauma, this is the first time in 12 to 15 years. And some of them just need a one- or two-time confirmation, a little bit of help. Some of them need years and years and years of therapy.

Mr. SMITH. This isn't limited to Vietnam veterans. It could be Korean?

Mr. REED. The service of this particular program is posttraumatic stress disorders. Certainly they have been here for a long time. All veterans have had them. There have been many incomplete diagnoses in the past years of such things as war neurosis, combat fatigue. Those were an understanding of the profession on the level of sophistication at that time. There are veterans of World War II and Korea sitting around right now that I feel sure have the same kind of problems Vietnam veterans have.

Mr. SMITH. A breakdown of what you see. What percentage would you say are Vietnam veterans, and the others?

Mr. REED. Of the ones that we see, they are 99 percent Vietnam veterans, because we are mandated to deal primarily, mainly with them. However, we have dealt with other cases from other wars. We certainly do not turn anybody down for our services.

Mr. SMITH. Thank you, Mr. Reed. Thank you, Mr. Chairman.

Mr. SHELBY. Mr. Stump?

Mr. STUMP. Thank you, Mr. Chairman. Mr. Pendleton, did I understand you to say you would discourage someone from going, blowing the whistle on waste or whatever?

Mr. PENDLETON. No, sir. I didn't intend to indicate that I would discourage them from doing it. I intended to indicate that I couldn't offer them any protection if they did.

Mr. STUMP. Why is that so?

Mr. PENDLETON. Because I don't feel that there is adequate protection built into that law. If you go around saying bad things about your boss, eventually he is going to find a way to stop you from saying those things.

Mr. STUMP. Well, if that is the case, then, I think we need to beef up this so-called protection of the whistleblower. But I think that that attitude of not encouraging someone to cooperate with someone under your supervision certainly makes a pretty good case for contracting out in some instances.

Mr. PENDLETON. I have no one under my supervision. They are my constituents and we have—I have personally went to staff meetings with people of this committee with instances of waste, and I don't discourage it. I just tell the man the way it is, that I cannot protect his job in that area. If I tell him anything else and he loses that job, that is my responsibility.

Mr. STUMP. Thank you, Mr. Chairman.

Mr. SHELBY. Congressman Gramm?

Mr. GRAMM. Mr. Reed, let me ask you one question. We had the Director of ACTION before the Veterans' Affairs Subcommittee on Education, talking about their new program which involved volunteers. I think they have gotten five or six of them that are ready to go online, and the basic idea is this: there are a lot of successful, well-adjusted people that came back from the Vietnam war.

Mr. REED. True.

Mr. GRAMM. And a lot of them came back from the war that weren't ready to divorce themselves from it. And I think many of them, now society is seeing their conflict in a different perspective, are eager to get back in and help the people who didn't make the kind of transition that they did. Are you familiar with this program? Have you gotten any information about it down at the field level?

Mr. REED. The only information we have had thus far at this point, thus far, has been the VISTA program under ACTION whereby they were trying to provide some job development and help which we have applied for, and have initially been approved for for people who would be working with our vet centers and a way to augment the staff that we have. Also I think it is an interesting point that you mentioned about there are a lot of well-adjusted Vietnam veterans who returned. I hope that I am one of them.

We have an advisory board where—in the vet center hereby we bring about successful Vietnam veterans from around the State of Alabama. And they help provide the direction of the vet center there. They also help us in what I think is an uppermost part of our job, and now—and particularly down the road, and that has changed our image that we have been hit with as being drug addicts, losers, and God only knows whatever else. The vet center should serve that dual purpose. The vet center should be out showing people that there are Vietnam veterans who come to us and say, "I am not going to the State Employment Service but I will

come hire guys you tell me to hire because I don't want to put up with the paperwork. I want other veterans." I see that as being one of the things. That is the community coming back through the successful Vietnam veteran. Again, it ends up being the Vietnam veterans helping each other.

Mr. GRAMM. I just wanted to say, as a person who has sat through the hearing, that I was very impressed with the basic ideas and the basic format. I would like to urge you to contact ACTION and to look at their basic idea and see how it might be applicable here. It is not an idea of allocating a lot of money. It is an idea of basically providing a little seed money to set up; the mechanism to draw these people in and hopefully generate a self-supporting program.

Mr. REED. Right. I would be very interested. Thank you.

Mr. GRAMM. Thank you, Mr. Chairman.

Mr. SHELBY. Mrs. Byron?

Mrs. BYRON. Thank you, Mr. Chairman. I really don't have any questions at this point. I think this is a very good cross section of three different views. I would say that I think we are beginning to see an increase of the vet center concept, and I think you have proven that in the fact that you find it necessary to open a second office in times as difficult as these, because everybody is cutting back on facilities. I think that is a positive thrust. I think that the longer you get the positive results and have awareness of the veterans who are out there, just not one aspect of help but across the board helping of the veterans, that you are going to be able to get help if you need an increase in your facilities. And I wish you well in your vet centers.

Mr. REED. Thank you.

Mr. SHELBY. Is that all, Mrs. Byron?

Mrs. BYRON. Yes, sir.

Mr. SHELBY. This will conclude our hearing. Mr. Pendleton, Mr. Goff, Mr. Reed, on behalf of the committee, we appreciate you coming. If you have additional material you want to send us, please do so. I think we are interested in what you are interested in, and we appreciate your candor and your appearance here. I wish to thank all of you in the audience for coming and sitting through this hearing. The hearing is now concluded.

[Whereupon, the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF ROBERT L. SLAUGHTER, M.D., CHIEF OF STAFF, VA MEDICAL CENTER, BIRMINGHAM, ALA.

I welcome the opportunity to appear before this Subcommittee to render comments regarding physician recruitment and retention within the VA Medical Centers of the State of Alabama and the DM&S as a whole.

As a matter of further introduction, I would indicate that I have been with the Birmingham VA Medical Center for the past ten years. I came to the VA initially as Chief of the Gastroenterology Section, a position that I have held until the present time. Since 1975 I have served the dual role of Chief of Staff and Chief of the Gastroenterology Section. This role requires my involvement in administrative matters but also requires a continued role as a clinician and teacher. I have been a part-time physician during these ten years, and I am one of the few remaining part-time physicians in the role of Chief of Staff.

The mission and primary goal of the DM&S is the delivery of quality, comprehensive patient care to eligible veteran recipients. Secondary goals, which actually complement and contribute to the achievement of the primary goal, include the maintenance of effective medical education and biomedical research programs. Achievement of these goals depends very heavily upon maintenance of an adequate and quality physician component. Recruitment and retention of physicians must, therefore, receive appropriate attention and consideration in ensuring that the necessary components for mission accomplishment exist.

When considering the adequacy or inadequacy of physician recruitment and retention, factors other than total numbers must be considered. Levels of competency that exist within these total numbers must be considered so that a level of quality as well as quantity can be established. Some of these factors include physician educational level, foreign versus U.S.-acquired degrees, specialty training levels, specialty board certification, continuing educational levels, licensing characteristics, average physician age, sex and other demographic characteristics, acceptance to membership in national and local medical societies and medical school faculty appointment. Assessment of these factors will allow comparisons between VA-appointed physicians and physician components of other systems, groups, institutions and the nation as a whole. Some data exist that will allow generalizations about the characteristics of VA physicians. Some such data can be found in the National Academy of Sciences National Research Council's Study of Health Care for American Veterans submitted to the Committee on Veterans' Affairs of the U.S. Senate in 1977.

The following generalizations of VA physicians can be made:

(1) A high percentage of VA physicians are board certified, and the majority are graduates of U.S. medical schools.

(2) Unlike other medical personnel groups, a large number of physicians are part-time VA employees and derive the remainder of their income from a medical school or from private practice.

(3) Full-time VA physicians are older than part-time staff physicians and include a higher proportion of women, a lower proportion of board certified specialists and a higher proportion of foreign medical graduates.

(4) Psychiatric hospitals have a higher proportion of full-time physicians, a lower proportion of board certification and a higher proportion of foreign medical graduates than general medical and surgical hospitals.

(5) A high percentage of part-time VA physicians hold faculty appointments. There are many factors that are important to physicians in choosing career objectives, working environments and employment locations. All surveys have indicated, as is the case with virtually all employee groups, that income or salary level is the most, or one of the most, important factors in making these choices. Where dissatisfaction exists, it is most commonly related to salary or income levels. Salary

levels must, therefore, be given first consideration in physician recruitment and retention.

Physicians are employed under Title 38 U.S.C. at salary levels established within this Code. Almost all physicians with more than the minimal qualifications are appointed within the Physician and Dentist Schedule at the Chief level. The salary range is from \$46,685 for the Chief Step 1 level to \$60,689 for the Chief Step 10 level, a range of \$14,004. A maximum basic pay level of \$50,112.50 has been established; therefore, the salary range is narrowed to only \$3,427.50. In actual appointment practices, most physicians who are board certified are initially appointed at the Chief Step 4 or 5 level. Both these levels are above the \$50,112.50 ceiling. This means that from the time of the initial appointment, no opportunity for salary growth exists. Further, if there is not a ceiling change during a particular year, there is not even a cost-of-living increase. One potential solution to this dilemma would be to appoint all physicians at a lower initial salary level. This would have a very adverse effect on recruitment capability since even a \$50,112.50 salary level is not competitive with private or group practice opportunities or even with most medical school faculty salary levels.

Public Law 94-123 of 1975, and later Public Law 96-330 of 1980, provided for special pay authority for physicians and dentists. These laws were helpful in providing additional salary for physicians and allowed the VA to become somewhat more competitive. Special pay levels of up to \$22,500 were possible. This places the salary ceiling possible at \$72,612.50. The minimum special pay for a newly appointed physician is \$13,000 if not board certified and \$15,000 if board certified. Even with these provisions, there exists very little salary growth potential for physicians and very little salary distinctions between the newly appointed staff physician and a major service chief. Special pay favors the full-time physician as opposed to the part-time physician. For the part-time physician, special pay dollars are associated with no fringe benefits. This particular feature is very detrimental to VA recruitment of medical school faculty where a comparable salary dollar, if paid by the medical school, would have an associate significant fringe benefit.

These laws have had a positive effect upon VA physician recruitment and retention although the degree or extent has not yet been accurately established. Some of these positive effects have been reported from our Alabama VAMC's, an example being the Tuskegee VAMC. Their total medical staff has increased from 44 in 1975 to a present level of 52. Gained specialties include internal medicine, emergency medicine, rehabilitation medicine, neurology and radiology. Similar examples could be given for many VAMC's in terms of an increase in total numbers. There is some supporting data that would suggest that there has been a slight qualitative improvement as well as a quantitative increase in appointed physicians. The benefit of these laws has been noted more in the more remote, nonaffiliated centers than in the urban located, affiliated centers.

Public Law 96-330 has benefited VA physician recruitment and retention, but it has not eliminated the problem. Continued emphasis on physician salary will be necessary. Changes that will recognize more favorably experience, expertise and seniority are needed so that greater growth potential for physicians within the system can be seen. The less favorable treatment of the part-time physician has resulted in more and more medical school faculty physicians who are unwilling to apply for and accept part-time VA appointments.

There are areas other than salary that must be reviewed that relate to physician recruitment. This involves the recruitment process itself. It is customary procedure in recruitment of physicians outside the federal sector to invite a potential physician for at least one and frequently more than one visit, usually one of which includes the physician's spouse. This done at no expense to the candidate. This usually has a favorable recruitment impact on the candidate, but more importantly it allows the recruiting group to personally observe the candidate and better assess his qualifications and desirability. Opportunity for such recruitment procedures for federal positions is very limited to non-existent. This places the selecting groups in a position of making recruitment decisions based upon written summaries of qualifications and verbal assessments by other individuals. Changes and provisions to allow more parallel recruitment practices by the VA facilities would provide a more competitive agency position.

The professional environment in which the physician must work has a major impact on physician retention. It is anticipated that as resources become more restricted with resultant restriction of service, particularly services to certain categories of veterans, the physician will feel that his professional ability to meet identified patient needs is becoming compromised, and a negative effect on retention will be seen. As services are restricted, it is of utmost importance that the legislative body assume the major role in determining where and to whom services

are to be restricted rather than expecting the physicians and professional staff to make these decisions themselves on a case-by-case basis. The professional is trained to and does think in terms of individual cases and not as a collective system. To force such thinking upon them will adversely affect their professionalism and their retention.

Physicians depend upon other members of the health care team for provision of quality care. Compromise of the availability of these other team members will adversely affect the physician's ability to practice his profession and lead to professional dissatisfaction. A near critical problem presently exists in maintaining an adequate supply of nurses to provide needed patient care. Many other members of the health care team are becoming more difficult to recruit and retain. Recruitment and retention of these categories of personnel must also be addressed. One provision that would have a positive effect and allow more needed management flexibility would be the inclusion of additional categories of health personnel in Title 38 U.S.C. Additional flexibility in nursing management is greatly needed to compete with non-federal institutions for needed nurse manpower.

In summary, physician recruitment and retention is not a major problem at present quantitatively; however, qualitatively recruitment and retention of a higher level of physicians would be desirable. It is anticipated that if present physician salary limitations remain unchanged more recruitment and retention problems will become obvious in the very near future. As the present trend in decreasing services, particularly to certain groups of veterans, progresses, it is extremely important that legislative and management actions protect the professional from being required to decrease services on a case-by-case basis. Changes in the allowable recruitment practices would allow a more positive approach to the entire physician recruitment process. Probably as important to the entire system as is physician recruitment and retention is the recruitment and retention of other health care team members, particularly nursing personnel.

Thank you again for this opportunity to address this Congressional Hearing.

PREPARED STATEMENT OF FLOYD MCNAIR, DIRECTOR, VA MEDICAL CENTER
MONTGOMERY, ALA.

On behalf of the VA Medical Center Directors of VA Medical Centers in Alabama we thank you for the opportunity of appearing before this subcommittee and providing you with information regarding the effect of budgetary constraints on hospital admitting procedures.

Basically we are and have been operating on fixed resources over the past few years. Efforts have been ongoing to (1) increase production, (2) shorten length of stay, and (3) redistribute resources to Medical Centers having the greatest need. The (MEDIPP) Medical District Initiated Program Planning process is intended to accomplish the latter.

Increasing demands for inpatient and outpatient services compounded by inflationary rise in costs of providing the services together with limited resources have dictated that each Medical Center lean toward conservation of treatment services for our veterans. We feel that increased demands can also be the result of veterans relocating from the snowbelt to the sunbelt as well as a constrained economy whereby veterans are turning to the VA Medical Centers for health care once their health insurance through employment is no longer available to them.

Most Medical Centers in Alabama have experienced demands for outpatient treatment over the past few years in excess of funding and workload allocations. For example, Tuscaloosa VAMC experienced 53,463 outpatient visits as compared to an assigned and funded workload of 40,886. Montgomery VAMC experienced 33,248 outpatient visits as compared to an assigned and funded workload of 32,300.

Medical Centers also have had to absorb the cost of employee health benefits. For example, Tuscaloosa VAMC absorbed \$62,600 in fiscal year 1981 which equates to \$82,000 in fiscal year 1982. These are recurring expenses which drain resources that would otherwise be available for veterans' health care.

In an effort to provide health care for as many veterans as possible within our austere budgets, certain painful choices are unavoidable. At present, under the priorities provided by Public Law 94-581 and further defined both by Title 38, U.S. Code, Chapter 17, and by VA Manual M-1, Part 1, we are able to furnish full care to Priorities I through III. We are, however, unable to provide care to all veterans falling in Priorities V and VI. The non-service connected veterans requiring post hospital care, Priority IV in many instances, receive modified care, i.e., limiting the length of time for follow-up care, and furnishing of medication. As additional budget

constraints occur, we will have to move upward in our list of priorities, such as further reduction to the NSC veterans in outpatient care and related benefits.

The Birmingham Veterans Administration Medical Center has been providing open heart surgery for veterans through a contract with the University of Alabama in Birmingham School of Medicine. We feel this is one of the best open heart surgery programs in the world as indicated by the fact that we have had veterans come here for this type surgery from as far away as Alaska and New York. Unfortunately, this excellent reputation causes the demand to exceed our resources. In the matter of heart surgery, as with any treatment, first priority is given to veterans rated service connected for that condition or for other conditions for which they are in receipt of VA compensation. Birmingham VAMC was basically funded for 200 cases; however, during the past fiscal year—fiscal year 1981—Birmingham treated 218 cases. The additional cost inevitably diminishes the facility's ability to cover other needs. Recently, in an effort to conserve resources, a decision was made to restrict acceptance of future cases for open heart surgery to veterans within VA Medical District 10, Alabama and Mississippi.

Additionally, increased cost without adequate funding may force Birmingham to limit the number of NSC veterans who will receive radiation therapy during fiscal year 1982.

Tuscaloosa VA Medical Center recently renovated and converted a Long Term Care Psychiatric Unit to an Intermediate Medicine Unit. The additional manpower required by the changed mission of this unit was not identified in the original project submission. Current ceiling and funding is not available at the facility to fully utilize this newly renovated unit. Efforts are underway at VA Central Office to attempt to remedy this situation. A waiting list of some 54 veterans requiring intermediate care is being maintained. Also, Tuscaloosa VA Medical Center closed a 62 bed psychiatric ward due to budget restraints and insufficient nurse staffing.

The magnitude of our overall problem in providing optimum care and maintaining staffing and facilities to serve eligible veterans may be judged by considering that we will receive in the vicinity of 6 percent increase in funding in fiscal year 82 over fiscal year 81 providing there are no further restrictions. This trend has been the case over the past few years when inflation has continuously increased, ranging from 11 percent to 15 percent annually. One can readily see that available funding does not offset inflation nor sustain our present level of activities.

PREPARED STATEMENT OF BERNARD D. PRICE, DIRECTOR, VETERANS
ADMINISTRATION MEDICAL CENTER, TUSCALOOSA, ALA.

We thank you for the opportunity to appear before this Subcommittee and provide you with the collective viewpoints of the Veterans Administration Medical Centers in the State of Alabama concerning the implementation of the Office of Management and Budget Circular No. A-76, relating to contracting with the private sector for services presently performed in their entirety by Veterans Administration employees. The Office of Management and Budget initially issued this Circular in 1955, and has reemphasized it at various intervals since that time. Now we are at the point where Circular A-76 has become a reality to our Medical Centers. A directive has been issued identifying 27 discrete activities for review under this program. The problem with contracting out is that it sounds like a good idea—in theory. If a private business is willing to do the job cheaper than VA employees, why not contract out the work? In practice, however, the VA has to provide health care in a real world. The real world does not operate in the manner contemplated by Circular A-76.

We anticipate spending hundreds of manhours developing for each activity statements of work, cost comparisons, and actual inhouse costs to determine whether we will keep our inhouse activities intact, or surrender them to private industry. For example, it is estimated that it will require approximately three man-months to fully review one discrete activity. If we do contract out, what impact will this have on management, employees and of utmost importance the veteran patient that we are sworn to serve? A number of questions come immediately to mind.

What happens when a VA Medical Center has contracted out for some essential service and the contractor's employees go out on strike? Such a job action could be highly disruptive to the Medical Center until the contractor settled his problems with his employees. We feel that any legal prohibition against strikes will be of questionable enforceability against contractors' employees. Consider please the impact of a strike upon laundry, environmental sanitation, plant maintenance facilities and food preparation service. The absence of such primary functions, that are as close to the patients as a physician, could cripple the facility to the point that

it could no longer operate. What happens when a company does poor work under its contract with a VA Medical Center? Firing a company that holds a contract with the Federal Government can be a long drawn out expensive process. VA Medical Center Directors could easily be forced to put up with inferior work until the contract expired. OMB Circular A-76 seems to assume that outside contractors would provide the same quality of work as VA employees. However, as many critics charge, this is almost never the case. Some critics have even stated that the quality of work begins its decline the day the contract takes effect. What happens when a contractor submits a short term undercutting bid against which VA employees cannot compete? The contractor could take his losses during the first year or so. Then when the VA has lost its ability to handle the work inhouse, he can go in for the kill, demanding a huge increase in the price for his services.

Difficulties with contractors are not the only problems VA officials expect to face if they are forced to contract out. Implementation of OMB Circular A-76 would fragment the management of the VA Health Care System. Management of individual Medical Centers and of the system as a whole would become incredibly complex, and a whole new layer of VA management would be needed to negotiate contracts, coordinate the activities of contractors, and make sure the employees of contractors were getting the job done.

We are firmly of the opinion that the nature and extent of the VA Medical Care Program does not lend itself to the contracting out theory. The responsibility for and delivery of care to sick and disabled veterans is an essential responsibility of the Federal Government. Quality of care and assurance of delivery should not be entrusted to a private business firm that does not also share the responsibility for or the commitment to the mission of the VA. We have serious doubts about the quality and timeliness of a product that is furnished by a contractor who can be supervised only at arms length. It is our position that, if any of the elements of quality, timeliness or control of the product or service are diminished in any respect, our responsibility in caring for the veteran will be compromised.

Special emphasis recruitment programs will be directly impacted. This will be most notable among the so called "big three" (food preparation and delivery service—Dietetic Service; hospital plant maintenance services—Engineering Service; and hospital custodial services and laundry services—Building Management Service) who will be the most vulnerable of the present list to be reviewed under Circular A-76. A large percentage of the employees in these areas are veterans who were hired under various veterans preference programs. The irony of hiring under veterans preference programs only to dismiss under another program seems all too obvious.

As the time draws closer to beginning the A-76 process in its full scope, we have experienced a growing fear and concern among our employees of its possible impact; fear for their jobs and fear for the overall impact upon patient care. We anticipate that these frustrations will continue to grow at an ever increasing rate through the entire review process. We, in management, are equally concerned, because we too have limited or virtually no experience with this category of work (contracting out) on which to rely.

The veteran patients that we serve must be our primary concern in this endeavor. What impact might they experience? Consider, for example, the possibility of one of the primary services, such as plant maintenance, laundry, custodial housekeeping or food preparation and delivery being compromised. The potential interruption to good patient care, I feel, is quite evident. The patients' attitudes, which affect their rates of improvement, will be impacted by the absence of the very essentials about which we are concerned. In the event that a contract encounters serious problems, the predicament that may face us all is a severe price to pay for economy only.

Another consideration in this exercise is the cost required to implement Circular A-76. To comply, we must undertake complex reviews to develop work statements that cover every minute detail of the work performed, comprehensive and detailed costs of our current inhouse activity, and finally detailed cost comparisons of bid price versus inhouse cost. These individual steps will require countless manhours—manhours that will hamper our ability to meet our current workloads with our reduced staffs. The manhours are only a part of the implementation problem. We also have concerns about the ability of our staff to carry out this complex task. The lack of expertise and experience that we currently possess in this area increases the possibility of errors or omissions, which would compound our potential problems. The individual steps for these reviews are guided by extremely complex instructions. Many of the factors to be applied in the required computations are judgmental in nature and subject to appeal by prospective contractors. These appeals could place the Medical Center in a state of limbo, awaiting final decision, and result in major recruitment and retention problems in the affected services. The problem is further compounded by the possibility of faulty technical specifications (statement

of work) resulting in performance below expected levels, and necessitating costly contract change orders. If done correctly, the resulting paperwork will represent an expenditure of voluminous manhours which no doubt will detract from our primary patient care mission.

I should note that VA Medical Centers, independent of the formal requirements of Circular A-76, are already buying commercial and industrial services from the private sector. This purchasing involves such activities as window washing, pest control, ambulance services, patient transportation and equipment maintenance and repair. Some of these services are economical and effective; others are less satisfactory. Many of these were clearly non governmental and in some cases were part time functions. As a result, it has been more economical to provide them through contract than through employing inhouse staff. These illustrations are indicative of the Veterans Administrations general reliance upon the private sector as specified in OMB Circular A-76. We feel this trend will continue, A-76 notwithstanding, provided it is deemed beneficial from both a management and an economic perspective. We will continue to strive to increase both efficiency and economy of operation. However, the judgment as to which services are to be performed inhouse should be based on considerations other than on just cost factors, such as availability of satisfactory service and the relative isolation of some facilities with concomitant nonavailability or limited availability of prompt service to maintain critical operations.

In conclusion, we find ourselves in a very precarious position. We feel obligated to implement Circular A-76 and conduct the required activity reviews. Yet, we are very concerned about the possible disruptions that will occur during its implementation. We are further concerned because the most basic of services are the ones most vulnerable. The entire process, from beginning to end, is filled with elements that detract from the control of our Medical Centers and impede our ability to manage.

We recently learned the House and Senate have both passed the "Veterans Disability Compensation, Housing and Memorial Benefits Amendments of 1981," and that this bill has now become law. Section 601 of that law proscribes the use of funds appropriated for medical care, medical and prosthetic research, or medical administration and miscellaneous operating expenses for conducting A-76 cost comparison studies. Hopefully, this law will provide us the necessary temporary relief to carefully consider the total impact of Office of Management and Budget Circular A-76 on the VA Health Care System. However, we firmly believe permanent redress from the requirements of this Circular is warranted for all of the reasons presented here today, and strongly urge your support toward that objective.

Again, we thank you for the opportunity to express our viewpoints on OMB Circular A-76. We will be happy to answer any questions you may have.

PREPARED STATEMENT OF ROY C. MCGINNIS, DIRECTOR, ALABAMA DEPARTMENT OF VETERANS AFFAIRS

I appreciate the honor and opportunity of appearing before the distinguished members of this sub-committee to give testimony on the implementation of the provisions of Public Law 96-330 relating to the recruitment and retention of medical personnel, the effects of budgetary constraints on hospital admitting practices, and the impact of OMB Circular on the ability of the Veterans Administration's Department of Medicine and Surgery to provide quality health care to our nation's veterans.

First, I want you to know that as Director of the Alabama State Department of Veterans Affairs, I represent some 422 thousand living veterans and their dependents in this State. In addition, our Department is accredited to represent the state organizations of The American Legion, AMVETS, Veterans of World War I, Inc., and the Military Order of the Purple Heart. Personally, I am an active member of all major veterans' organizations, a veteran of this nation's last 3 wars, and an Ex-POW of WWII. I point out these facts so that you may have better insight into the viewpoints expressed in my testimony.

It would be foolish of me to try to leave the impression with you that I have great knowledge of all the technical aspects of the "ins and outs" of the subjects of this hearing. I, therefore, depend on those who work directly with these complex subjects for their technical competency in their observations and actions. So, rather than my testimony reflecting technical expertise on the subjects, it reflects observations and opinions from an environment outside the VA system. In other words, it comes from the day to day operations of my office, coming in contact with veterans who use VA facilities, mixing with members of veterans' organizations, etc.

Recruitment and Retention of Medical Personnel.—We think that the health-care personnel amendments in Title I of Public Law 96-330 should greatly relieve this problem throughout the VA system if nothing was allowed to interfere with the implementation of those amendments. As I understand it, the continued shortage of physicians and other personnel in the system is now due to budget constraints. This is one area where the average veteran does not understand the process. For example, they were proud of Congress when they went all out to override President Carter's veto in passing Public Law 96-330, yet some of the same members voted to cut the budget which prevented full implementation of the benefits in the law.

So, despite these beneficial amendments, there are still critical shortages of full-time VA physicians and other medical personnel. An example close at hand is the fact that an overwhelming majority of physicians at the Birmingham VAMC, including the Chief of Staff, are in a part-time status. Speaking of Chiefs of Staff in a part-time status, we commend the Congress for making the provision in Public Law 96-330 to require all future Chiefs of Staff to be in a full-time status. However, with no reflections on anyone personally, the grandfathering of those in a part-time status, still leaves an unsatisfactory situation wherever they exist. The point of dissatisfaction relates mainly to VAMCs affiliated with medical schools. When a Chief of Staff works part-time for a medical school and part-time for a VAMC, there is always a doubt whether a veteran patient's clinical interest is properly represented in administrative arrangements between the school and the VA.

While addressing the recruitment and retention of medical personnel, I think I should remind you of the many valid complaints of veterans, other than personnel shortages, related to this area. There are complaints of non-communication, insensitivity, or lack of sympathy to veteran patients. A continuous stream of complaints also comes from veterans because of being unable to communicate with the many foreign doctors in the system. We think that any recruitment and retention program should aggressively try to prevent or weed out these sources of contention.

The Effects of Budgetary Constraints on Hospital Admitting Practices.—I am unable to give any detailed testimony on the effects of budgetary constraints to the overall VA hospital admitting practices, but from what I read thousands of beds have been closed down because of nursing and doctor shortages and several new hospitals to be constructed were cancelled. With the President's latest proposal to cut VA medical funds by another \$451 million, it appears to me that if such is enacted it will have a disastrous effect on the entire VA medical system.

Perhaps the following examples of how budgetary constraints have affected the 4 VA hospitals in Alabama are typical nationwide. As far as I can determine, veterans needing hospitalization at 3 of the hospitals are no problem; however, at the Tuscaloosa hospital there is a list of 44 veterans waiting to be hospitalized in the intermediate medical care unit. This, I understand, is due to lack of funding for staffing and the operation of this new unit. The Tuscaloosa hospital also recently closed a 62-bed psychiatric ward due to budget restraints and insufficient staffing.

As far as outpatient treatment for non-service connected veterans, budgetary constraints have just about eliminated this very important benefit. For example, the Birmingham hospital will not schedule an appointment for these veterans unless they were discharged from the VA hospital during a period of 1 year. They also will not furnish medicine at VA expense after 30 days from discharge even though outpatient treatment is authorized for a period up to 1 year.

Another example of where budgetary constraints are quoted as the cause was that Medical District #10 tried to force the closing of the surgical services at the Montgomery VAMC beginning on October 1, 1981. That effort was temporarily stopped, but is again a prime target for the year 1982. The Montgomery VAMC has 120,000 veterans in its primary service area, serving 24 Alabama counties and 6 counties in northern Florida. We think that the elimination of the surgery service in this hospital would be a first step in closing the facility and would be an unnecessary disservice to the veterans using the facility.

Budget constraints have also forced the Birmingham VAMC to limit their 1982 open heart surgery cases to 200 annually and to restrict them to patients residing in the primary service area of Medical District #10. In 1981, they had 218 cases coming from locations all over the country.

There are not 12½ million veterans of WWII, whose average age is 61. They are coming into that time of life when they will become increasingly susceptible to the catastrophic illnesses that accompany advancing age—cancer, heart disease, stroke, among others. These are the illnesses that will force many of these veterans to turn to the VA for care—something they have not had to do before this time.

The demands for medical care have been created by the fact that America has had four wars in this century, and has created a veteran population in excess of 30 million. Care for those veterans who will need and seek it is an inevitable cost of

the wars in which the nation has engaged. It is our confidence that Congress, representing the people, will not forget that fact, and stop the budgetary constraints affecting their care.

Impact of OMB Circular A-76 on the ability of the VA's DM&S to provide quality health care.—As you know, the OMB has decided to implement provisions of this circular which mandates the VA to make studies for the purpose of "contracting out" certain functions and services provided by the VA Department of Medicine and Surgery. Primarily these functions pertain to services in VA hospitals such as: pharmaceutical services, plant maintenance services, food preparation and delivery services, patient administrative services, supply services, laundry services, etc. OMB states the basic rationale behind this circular is that it is the Government's general expression of its long standing policy of not competing for business with citizens, and for relying on private enterprise to furnish goods and services the Government needs.

We have no quarrel with this stated rationale, but as expressed by veterans throughout the nation, Alabama veterans hold the firm opinion that the nature and responsibilities of the VA medicare program do not lend itself to the "contracting out" principles. The only exceptions would be outside ground maintenance, pest control etc. When considering the actions contemplated by OMB the following should be kept in mind. So far as I can determine the Government experience in "contracting out" raises serious questions as to the cost-effectiveness of this method. True, any initial contract must realize at least a 10-percent savings over the in-house cost; however, when the contract is renewed after in-house capability is dismantled, the costs were dramatically increased. Usually what the Government contracts out, it loses control over. This lack of control nearly always results in lower quality and quantity of service. What about the veterans employed in preferential jobs, such as guards, elevator operators etc? What about other Federal employees? Would a contractor have to take them? What about strikes of personnel under private employment contracts?

It has been estimated that some 4,000 cost studies will be required by the VA to implement the provisions of Circular A-76. With some 1,000 staff hours needed to complete them, where will the millions of dollars cost come from? Congress has already sent to the President the Veterans' Disability Compensation, Housing and Memorial Benefits Amendments of 1981—Senate Bill 917 which prohibits the use of any funds appropriated for the VA's medical care, medical and prosthetic research, or medical administration and miscellaneous operating expense accounts for the purpose of conducting any cost comparison studies as required by OMB Circular A-76. It is significant to note that in the compromise agreement reached by the House and Senate Veterans Affairs Committees they stated—"The Committees believe that no further steps should be taken to implement Circular A-76 cost comparison studies in VA health care facilities unless the Congress has expressly decided to make funds available specifically for that particular purpose." When you consider the cost of implementation, doubtful savings in the program if adopted, the fact that the cost of VA Medical Care is already 18 to 22 percent lower than private enterprise (as reported in a VA study last summer), then the cost-effectiveness aspects of the proposal become a mirage.

It seems to me that the Government has a sacred trust, in addition to the legal obligations in Title 38 USC to provide comprehensive, timely and high medical care to the nation's sick and disabled veterans. The Government first acknowledged its obligations to provide quality health care to veterans in the passage of the World War Veterans Act in 1924. It faced up to this trust when it established the VA in 1930 and put all Federal veterans' health care under the new agency. It more clearly defined Congressional intent in this regard by the establishment of the VA Department of Medicine and Surgery in 1947. The need, so well addressed back then, has not lessened. In fact, the need is greater now than ever before with the millions of veterans previously mentioned becoming eligible for medical care for the first time. In addition, if the VA system is ever going to be used as a back up system for military casualties in event of war, the "contracting out" method is no way to insure its use.

In view of all the negative aspects of the "contracting out" of VA services as advocated in OMB's Circular A-76, which I feel sure have been well documented in other hearings before the House Veterans Affairs Committee, we in Alabama fail to see how the OMB proposal could receive favorable action by the Congress. I again thank you for the opportunity and honor of expressing my view point.

PREPARED STATEMENT OF GORDON SHEWMAKE, COMMANDER, DEPARTMENT OF
ALABAMA VETERANS OF FOREIGN WARS OF THE UNITED STATES

Thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the State of Alabama, Veterans of Foreign Wars of the United States.

My name is Gordon Shewmake and it is my singular honor to serve the more than 27,092 members of the VFW in Alabama as their State Commander.

The recruitment and retention of fulltime American educated health-care personnel is a continuing and increasing problem not only in our hospitals at Birmingham, Montgomery, Tuscaloosa and Tuskegee, but throughout the entire VA health-care system. Recently, 90 percent of the physicians at the Birmingham Medical Center were parttime physicians and other staffing deficiencies were numerous and most critical in the nursing, laboratory and radiology services.

One of the provisions of Public Law 96-330, which was overwhelmingly passed by both houses of the United States Congress following the President's veto, authorized a Veterans Administration Health Professional Scholarship Program to provide scholarships to students enrolled in physician or nursing training in exchange for a commitment by the students to serve as fulltime employees within the Veterans Administration for a specific period of time. Unfortunately, no funding for this program was included in the Veterans Administration fiscal year 1981 budget. When our National Legislative Director testified before the Appropriations Committee of both the United States Senate and House of Representatives with respect to the fiscal year 1982 budget, he requested \$12 million be appropriated for the scholarship program; \$7 million for physicians and \$5 million for nurses. It is my understanding that as the 1982 appropriation stands at the moment, \$4 million is earmarked to start up the nurses' scholarship programs but no funds are included for physicians.

Mr. Chairman, from my observations and that of our VFW Service Officer, once a veteran is able to overcome the obstacles to being admitted for care in our VA facilities, the treatment and care provided is professional and of high quality. However, more and more veterans are being denied treatment and never make it to a hospital bed even if ill and I'm not merely speaking of those with non-service-connected disabilities but, those with service-connected disabilities. As a direct result of budgetary and personnel constraints, veterans are routinely denied care and referred to community facilities as charity patients. To me this is abhorrent because no honorably discharged veteran who served during a period of war should be denied prompt and competent care by the VA. Along this same line and highly disturbing to me, to the membership of the VFW and the veterans of this state is a recent statement made by the new Administrator of Veterans Affairs, Robert P. Nimmo, that "Under today's budget constraints and the soaring cost of medical care, the VA cannot continue to provide full medical care to all veterans regardless of eligibility . . ." Furthermore, we have heard that an annual income of \$15,000 a year would disqualify a veteran for care furnished by the VA regardless of his or her financial obligations and the seriousness of the illness. If all this isn't bad enough, we are now told that the Administration has proposed slashing another \$451 million out of the VA budget for 1982 and the bulk of that money, \$296.9 million would be cut from medical care.

Mr. Chairman, you know as we know and as our National Officers have stated at the highest levels within the Administration and before various committees of the United States Congress, further cuts simply cannot be made in the VA budget without doing irreparable violence to the hospital and medical care system of the benefit programs, or both.

Another highly disturbing concept of the Administration is the contracting out studies required of the Veterans Administration by Office of Management and Budget Circular No. A-76. Appended to my testimony is an extract of the contracting out studies to be initiated at the Veterans Administration Medical Centers at Birmingham, Montgomery, Tuscaloosa and Tuskegee which range from pharmaceutical services to all medical records, food service and many other functions. It is my understanding there would be more than 5,000 studies throughout the VA hospital and medical care system at an estimated cost of \$39.1 million. Furthermore, the Administration envisions eliminating as many as 30,000 positions within the VA of which more than 60 percent are now filled by veterans. In other words, contracting out would effectively circumvent veterans preference in federal employment, a benefit the VFW fought long and hard to achieve and retain. In addition and as pointed out by our National Representatives in testimony before this very Subcommittee in Washington, our Field Representatives who survey VA hospitals and hold conferences with medical center directors are convinced that the imposition of OMB

Circular No. A-76 in areas directly impacting patient care would, literally, be catastrophic to the VA hospital and medical care system for the following reasons:

1. There would be a loss of control by management and service chiefs where they would not be able to deal directly with employees, but would be required to deal with the contractor.

2. Many good, reliable and motivated VA employees would be lost. There is no assurance that current VA employees would be engaged in the private sector.

3. It is believed that the team concept used in building management, engineering and other services of a hospital would no longer be as effective.

4. The employee/patient relationship would most likely cease to exist.

5. The real possibility of a lack of concern and compassion for patients on the part of contracted employees.

6. A contracted employee would not be available for or under any obligation to perform collateral duties.

7. Further difficulty would occur in the coordination of various activities between services.

8. An increase in equipment abuse and possible theft is anticipated.

The deep concern of the VFW with respect to contracting out is reflected in our current Resolution No. 622 passed by the voting delegates to our 82nd National Convention and appended to my testimony. Our opposition to contracting out is also embodied in our Priority Legislative Goals.

Mr. Chairman, in recent years medical care for our nation's veterans has become more and more difficult to obtain due to budgetary and personnel constraints, the number of hospital beds have continued to be reduced and this pattern simply cannot continue if we are to have a viable health-care system and honor the nation's obligations to those who have served honorably in our armed forces during periods of war and hostility. We look to this Subcommittee, the full Committee and the Congress of the United States to continue to fully honor the commitment made by George Washington when he stated, "It (benefits) was a part of their hire . . . it was the price of their blood and of your Independency, it is therefore more than a common debt, it is a debt of honour . . ."

In conclusion, permit me to compliment the Committee for not having caved in to the Administration's attempt to cut the VA budget by \$831 million earlier this year and we look to you to use every resource at your disposal to defeat the current proposal to further reduce the 1982 VA budget by another \$451 million.

This concludes my testimony, Mr. Chairman, and I will be happy to respond to any questions you may have.

RESOLUTION No. 622

OPPOSE CONTRACTING OF VA SERVICES

Whereas, an area of increasing concern is the contracting out of service within the Veterans Administration as proposed by the Office of Management and Budget Circular A-76; and

Whereas, the implementation of such a drastic change in the method of providing service at Veterans Administration Health Care facilities will tend to affect adversely the quality of care of the veteran increasing the potential of employee strikes; and

Whereas, the use of commercial contractors will tend to create problems of untold magnitude and will disrupt the cohesiveness essential to the effective direct and indirect patient care operational capability of Veterans Administration health care delivery; and

Whereas, contracting out of patient care services in Veterans Administration Health Care facilities is in no way comparable to the contracting out of business-commercial type services in other agencies not related to health care both in the federal government or the private sector; and

Whereas, the continuing contracting out of services will seriously jeopardize veterans employment rights and represents an attack on veterans preference laws diminishing the number of full-time jobs otherwise available to war veterans; now, therefore

Be it resolved, by the 82nd National Convention of the Veterans of Foreign Wars of the United States, that we and the Congress strongly resist and urge the Veterans Administration to oppose any further attempt by the Office of Management and Budget to implement the provisions of OMB Circular A-76.

Adopted by the 82nd National Convention of the Veterans of Foreign Wars of the United States held in Philadelphia, Pennsylvania, August 14-20, 1981.

PREPARED STATEMENT OF LEWIS E. MCCRAY, ALABAMA NATIONAL EXECUTIVE
COMMITTEEMAN, THE AMERICAN LEGION

Mr. Chairman and gentlemen of the Committee, I am pleased today to bring to the attention of the distinguished members of the Sub-Committee of the House Committee on Veterans Affairs the position of the American Legion in regard to the provisions of OMB Circular A-76, Recruitment and Retention of Medical Personnel at VA Medical Centers and Admissions Policy at VA Medical Centers.

I first will remind members of the Committee of the importance of recruitment and retention of medical personnel in VA Medical Centers. The American Legion has long called for special consideration in pay and benefit for these personnel. All too often the VA Medical Centers have failed to keep pace in bringing in individuals who can meet medical needs of American veterans. As you will recall in 1980 Congress passed Public Law 96-330 which aided the VA Medical Centers in this problem, and the Legion is grateful that Congress kept its commitment and overrode Carter's veto. The Legion continually supports the efforts of many members of Congress in the problem of recruitment and retention of medical personnel.

Admissions Policies of the VA Medical Centers are of great concern to the American Legion and it is our belief that the facilities should be well-staffed and available to the veteran as needed. Our first concern, of course, is the veterans with service connection and we are particularly concerned for the needs of the veterans who served in Viet Nam. Agent Orange is a baffling and continuing problem and the American Legion calls upon Congress to see that adequate and expeditious treatment is rendered these veterans.

The subject of OMB Circular A-76 is: Policies for Acquiring Commercial or Industrial Products and Services Needed by the Government. The American Legion resolutions submitted with this statement make clear the seriousness with which this organization views the possible effect of Circular A-76 on two matters of vital concern; namely jobs for veterans, and delivery of quality care on a timely basis to sick and disabled veterans.

The American Legion has no essential quarrel with the stated purpose of Circular A-76: to establish the policies and procedures used to determine whether needed commercial or industrial type work should be done by contract with private sources or in-house using Government facilities and personnel. Nor do we argue with the statement in the Memorandum: In a democratic free enterprise economic system, the Government should not compete with its citizens.

However, in consideration of the above statements, the following must also be kept in mind. The provisions of section 3310 of title 5, United States Code, require that positions of guards, messengers, elevator operators and custodians be restricted to veterans, and that the Government is legally obligated to provide a comprehensive program of medical care to the nation's sick and disabled veterans.

The Veterans Preference Act of 1944, as amended, makes clear the intent of Congress that veterans shall have preference in Federal employment. Section 3310 of title 5 USC further reserves certain entry level positions in Federal service to veterans. These provisions in law make clear the intent of Congress that the Federal Government shall move in a positive way to provide employment opportunities to those who have honorably served the nation in its Armed Forces. This is a most appropriate policy and is imbedded in the history of the nation, all the way back to the post-Revolutionary period.

Experience shows that section 3310 has been observed mainly in the breach in that these positions have not been reserved for veterans. It has been pleaded that veterans are not available for all these positions. This is not true. What inhibits the employment of veterans under section 3310 is contracting out; the absence of a recruitment program by the Office of Personnel Management for these positions; and the fact that veterans generally, do not know they are eligible for these positions.

If, in compliance with A-76, an increasing number of activities in the Federal service are contracted out, the result will be that thousands of veterans will lose their jobs, and other thousands will be denied opportunity for employment, at a time of serious unemployment throughout the nation, especially among younger people, which includes the Vietnam Era generation, to whom this Government has a special obligation.

We believe the experience of the Government thus far in contracting out raises serious questions as to the cost-effectiveness of this method of governmental oper-

ations. What the Government contracts out, it loses essential control over, and experience shows this lack of control results in diminution of both quality and quantity of service to the general citizenry.

We do not say categorically that there are no Governmental functions that should not and could not be contracted out. We do say that experience thus far raises serious questions of whether or not contracting out has saved the Government any appreciable amount of money, and whether or not it has improved or even maintained service.

We believe Congress should impose stringent oversight on any and all contracting out activities undertaken by the Executive Branch. We believe the Executive Branch should be required to satisfy conclusively the goal of cost-efficiency and cost-savings achieved by contracting out, and that these considerations should be carefully balanced by Congress with the equally desirable goal of providing employment opportunities to the veteran population, to which this Government has a special obligation as to its economic well-being.

The other consideration we shall address in this statement is the effect of the implementation of A-76 on the medical care program operated by the Veterans Administration.

As stated earlier, the objective of that program is to provide comprehensive, timely and high quality medical care to the nation's sick and disabled veterans. This obligation is more than a justifiable benefit; it is in fact a sacred trust. The Government first faced up to this trust when it established the Veterans Administration as an agency in 1930, and gathered all Federal veterans health care activities under the new agency. It acknowledged the nation's obligation to provide health care to veterans with passage of the World War Veterans Act of 1924. And it more clearly defined Congressional intent in this regard with the establishment of the Department of Medicine and Surgery in 1947. From those actions, and the subsequent volume of legislation dealing with veterans medical care, the intent of Congress to meet this sacred trust is clearly manifest. We say it is a sacred trust because included in the Congressional mandate is the acknowledged responsibility of the Government to care for those who are disabled as a result of military service.

The fulfillment of the mandate to provide comprehensive medical care devolves into the myriad activities of the Department of Medicine and Surgery, many of which are now under consideration for disposal through implementation of A-76.

The American Legion does not believe the Veterans Administration can conduct its medical care program properly if it proceeds to contract out any of the functions of that program, with very few exceptions.

VA has indicated to OMB that it will consider only those activities for contracting out that do not involve "hands-on" care. That is not a sufficient delineation of the extent of direct VA responsibility for care of patients. The fact is that practically everything that is done for the patient, directly or indirectly, affects his care and treatment, and can only be considered to be a direct responsibility of the VA.

As examples of what we mean, let us consider just two elements of patient care—dietetics and laundry.

We understand serious consideration is being given in current VA studies to the contracting out of dietetic service in VA Medical Centers. The way this would work, as we understand it, is that VA dietitians would continue to prepare and supervise menus and nutrition diets prescribed by physicians. The food preparation and delivery would be contracted out. At first glance this proposition sounds feasible. But on closer examination it is not.

In the first place, VA dietitians could not assure the quality of food preparation if the food workers were not under their operational control. This could affect the quality of the food prepared and served to patients. Second, what if the contractor experienced a strike? What guarantee could be given for preparation and delivery of food and special diets (which are prescribed for the majority of patients in any hospital)? It has to be realized that the absence of one meal, or of one special diet could, in the extreme, cost the life of a very sick patient. How would VA ever answer to that eventuality? It certainly would not suffice for OMB to declare they never intended for that to happen. The loss of even one patient in these circumstances would lead to charges the VA would never be able to defend.

The obvious conclusion to draw from this example is that the food service in a VA Medical Center must be considered to be the complete and final responsibility of the Medical Center management and the physicians who are treating the patients.

Our second example is that of laundry service. Here again, at first glance there might seem reason to conclude that laundry service in a Medical Center could be contracted out. However, clean and sanitized laundry is an essential element of hospital operation. A hospital uses large quantities of laundry on a daily basis. The availability of that laundry is essential. Absence of clean and sanitized laundry for

one day would cripple the hospital operation. Absence for several days would cause the hospital to discontinue treating patients. This fact makes it obvious that providing clean and sanitized laundry must be guaranteed, and therefore must be under the complete and final control of hospital management.

These two examples are intended to illustrate the fact that there is very little going on in a hospital that can be entrusted to any except the management and functioning staff of the hospital. Medical care cannot be equated with any other types of activity. The care and welfare of patients must be assured by the complete control and ultimate responsibility of the hospital staff. This leads us to conclude that the possibility of contracting out hospital operations is a very dubious idea.

On appraising the multiple activities that comprise the functioning of a Medical Center, our conclusion is that the only types of activity that would seem to lend themselves to contracting out would be such things as ground maintenance, window washing and pest control. These activities do not impact directly on patient care, even though they are important. We do think that Congress should keep in mind, even in regard to these selected activities, the matter of jobs for veterans. Would savings to the Government, which we believe would be minimal, justify the loss of jobs that could well be done by deserving veterans? That is a question for both Congress and the Executive Branch to keep in mind.

The problem we of The American Legion have with the concept of contracting out as it applies to the Veterans Administrations is that the possibility of dollar savings to the Government must be placed against the special mission of the VA, not only to provide benefits and services to veterans, but also to be an exemplary Federal employer of those who have served the nation in its Armed Forces.

It is our petition to the Subcommittee that Congress will insist on participating in any decision that may be projected by the Office of Management and Budget as to the propriety of contracting out for Government services. Most certainly, as far as VA is concerned, any decision on contracting out of any VA activity, must be balanced against the mission of the agency and its role as standard bearer of the Government's commitment as a principal employer of America's war veterans.

NATIONAL EXECUTIVE COMMITTEE MEETING OF THE AMERICAN LEGION, APRIL 20
TO MAY 1, 1980

RESOLUTION NO. 2

Commission: National Veterans Affairs and Rehabilitation.

Subject: Oppose Veterans Administration Department of Medicine and Surgery contracting out in-house services deemed essential for integrated quality medical services to eligible veterans

Whereas, Office of Management and Budget (OMB) Circular A-76 established for Federal agencies "Policies for acquiring commercial or industrial products and services needed by the Government"; and

Whereas, the Veterans Administration Department of Medicine and Surgery has compiled an initial but as yet incomplete inventory of commercial and industrial activities at all of its facilities, in compliance with the requirements of OMB Circular A-76; and

Whereas, the Veterans Administration Department of Medicine and Surgery has begun a review of this inventory of commercial and industrial activities to determine which activities must be retained in-house and which will be scheduled for cost comparison review in compliance with OMB Circular A-76; and

Whereas, the Department of Medicine and Surgery is developing and will publish shortly an information letter to Directors of all Veterans Administration Medical Care facilities, advising that under no circumstances are they to undertake Circular A-76 reviews without specific approval or direction from the VA Central Office; and

Whereas, it appears certain the Veterans Administration Department of Medicine and Surgery plans to develop and publish a cost comparison review schedule of those activities which are amenable for contracting under the aegis of OMB Circular A-76; and

Whereas, The American Legion has opposed and continues to oppose those efforts of the Office of Management and Budget which tend to fractionate the Veterans Administration as the sole Federal agency responsible for the delivery of quality hospital and medical services to the Nation's veterans; now, therefore be it

Resolved, by the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, April 30-May 1, 1980, that The American Legion shall vigorously oppose Veterans Administration contracting out of those services or activities deemed essential for retention in Veterans Adminis-

tration medical care facilities in order to insure the timely delivery of quality health care to the Nation's eligible veterans.

SIXTY-SECOND ANNUAL NATIONAL CONVENTION OF THE AMERICAN LEGION,
AUGUST 19-21, 1980, BOSTON, MASS.

RESOLUTION NO. 696

Committee: Economics.

Subject: Enact legislation to prevent Federal agencies from contracting out services that eliminate necessary Federal jobs.

Whereas, Many Federal agencies continue to contract out certain programs of services thereby causing a reduction in the number of full-time Federal employees, although in most instances the contracting out of such services is more expensive to the government than doing the work in the agency with permanent, full-time employees; and

Whereas, By provision of law, certain positions of building maintenance and security are to be filled only by veterans preference eligibles when they are on the registers, but these jobs are frequently the first to be contracted out; and

Whereas, The continuing contracting out of services reduces the number of full time Federal jobs that otherwise could be filled by war veterans; now therefore be it

Resolved, by The American Legion in National Convention assembled in Boston, Massachusetts, August 19, 20, 21, 1980, that The American Legion urge, Congress to enact legislation to prevent Federal agencies from contracting out certain projects that could be performed by the agency using full-time civil service employees.

NATIONAL EXECUTIVE COMMITTEE OF THE AMERICAN LEGION, INDIANAPOLIS, IND.,
MAY 6-7, 1981

RESOLUTION NO. 13

Committee: Economics.

Subject: Oppose contracting out in the Federal Government as it affects those exclusive positions for preference eligibles.

Whereas, 5 United States Code 3310 (Public Law '89-554) provides that the positions of guards, elevator operators, messengers and custodians are restricted to preference eligibles; and

Whereas, The federal government never fully sought to see that those positions are to be given to preference eligibles; and

Whereas, Those positions have been contracted out to private government contractors thus denying a preference eligible the opportunity to compete for those positions; and

Whereas, The federal government intends to increase, through private contractors, those services, thus circumventing the intent of the above provision; now therefore be it

Resolved, By the National Executive Committee of the American Legion assembled in Indianapolis, Indiana, on May 6-7, 1981, that The American Legion oppose the contracting out of those positions as provided in 5 United States Code 3310 and seek all reasonable means to halt this practice as it applies to preference eligibles.

PREPARED STATEMENT OF W. R. WIGLEY, COMMANDER, DISABLED AMERICAN
VETERANS, DEPARTMENT OF ALABAMA

This has reference to your recent letter advising me as to the upcoming Congressional Hearing scheduled for Tuscaloosa, Alabama on October 30, 1981. In your letter of October 6, 1981, you requested that I provide you with the position of the DAV Department of Alabama as soon as possible.

As the Department Commander for the Disabled American Veterans in the state of Alabama, and on behalf of the approximately 8,000 members currently in our organization state-wide, I am very happy to have this opportunity to express the position of the DAV in respect to the implementation of the A-76 process. Indeed, I would state that on behalf of the 40,000 disabled veterans who reside in the state of Alabama, I am particularly glad that you have given me the opportunity to express our opinion.

The Disabled American Veterans is admittedly opposed to the implementation of the A-76 requirements not only on the VA's Department of Medicine and Surgery, but, also on the VA's Department of Veterans Benefits. We, in the DAV, feel that the imposition of the A-76 requirements on the Veterans Administration in these two respects would cause immediate decay and rapid deterioration of the quality care presently provided by the Veterans Administration Medical Centers and the Veterans Administration Regional Offices.

When one looks at the total affect which the A-76 process would have on the Veterans Administration, it is going to hit the VA right where most damage can be done. The OMB Circular A-76 indicates that all areas will be open for private contracting which would include routine physical examinations, surgical, medical, dental, and psychiatric care, laboratory and pharmaceutical services, eye and hearing examinations, food preparation, plant maintenance, supply and custodial functions. All of these would be involved at all of the 172 Veterans Administration Medical Centers and 200 Clinics throughout the country.

At the Regional Office level various functions would also be subject to the same procedures under the A-76 guidelines. Some of the more important functions affected would be that in medical transcriptions, key punch, and various other vital functions.

It has been estimated by the Veterans Administration that it will take approximately 3,880 studies or 20 to 30 such studies at each of the VA Medical Centers in order to comply with the demands from the Office of Management and Budget. These studies are not only going to be time consuming, but are also going to be extremely expensive and it has been estimated that the studies in and of themselves will cost more than 29 million and the expense of this study will be paid for with funds that would have been used for medical treatment purposes. The number of man hours that it will take to complete the 3,880 studies have been estimated at approximately 1,000 staff years. As we all are aware, the Veterans Administration is already operating under very severe employment restrictions and limitations. The implementation of these studies will only cause more time to be taken from the actual delivery of health care to the disabled veteran.

The Disabled American Veterans is very concerned as to exactly how the implementation of the A-76 process would affect both the Department of Medicine and Surgery, and the Department of Veterans Benefits. We are concerned because the contracting out of this work to private companies can easily create enormous and unforeseen problems. One must be ever aware that private companies could go out on strike, thereby, creating immense problems for either a VA Medical Center or a Regional Office. Also, of great concern would be the privacy of the veteran's records both at the VA Medical facility as well as the VA Regional Office. In the area of medical transcription, private companies would have access to very sensitive and private information on veterans whom they will be dealing with. The integrity, in our opinion, of the Privacy Act would be in jeopardy with the implementation of the A-76 procedures.

I will grant the fact that there is a possibility that a private contractor could come in and contract a function on a less costly basis than the VA. However, after the implementation of the private contract the Veterans Administration Medical Center and the VA Regional Office would then be at the mercy of the private contractor. That contractor could then demand a much greater price after the initial agreement and the VA would be without ability to do anything other than pay the increased price demanded by these companies.

We, in the DAV, feel that the Veterans Administration should receive a total exemption from the A-76 requirements in order that the Veterans Administration may continue to provide quality patient care at all of the VA Medical Centers and at all of the VA Regional Offices.

The Disabled American Veterans does not, in any way, shape, or form, foresee the implementation of the A-76 process as a good thing for the Veterans Administration or, indeed, for the disabled veteran whom that agency serves. We conclude that the 3,880 studies which will be required, the approximate 1,000 staff years it will take to do the studies, and the approximately 29 million dollars it will cost to pay for such studies can be put to much better use in providing quality care for this nation's service connected disabled veterans.

We ask you, Chairman Montgomery, to please consider all of this when you and your committee take up the A-76 process requirements as presently outlined by the Office of Management and Budget. We cannot stress the importance of maintaining the present integrity of the VA Medical system, the ability of the VA to do what must be done to provide adequate care for the disabled veteran, and the ability of the VA to provide the privacy which all veterans deserve. The implementation of the A-76 process would simply tear down all that has been accomplished and, in our

opinion, would cause nothing but chaos on the management of the individual hospitals and on the systems as a whole because of the complexities involved under the new guidelines. The implementation of the A-76 process would, in our opinion, create the need for a whole new layer of VA management to provide for the negotiation of contracts, the coordination of activities of contractors, and to make sure that the employees of the contractors were doing exactly what they were contracted to do.

As the Department Commander for the DAV in the state of Alabama, I ask your consideration of all of the statements which I have expressed in this statement. We do not feel, in the DAV, that the implementation of the A-76 process on the Veterans Administration would be in the best interest of the Veterans Administration and continue to feel that the VA, both in the Department of Medicine and Surgery as well as in the Department of Veterans Benefits, should be excluded from the A-76 requirements.

Thank you very much for giving me the opportunity to express our opinion in regards to this very controversial proposal to implement the A-76 process. We, in the DAV, only ask that you, as Chairman of the House on Veterans Affairs Committee, and your members look at this subject in the light in which we see it and I think that you will, indeed, find that the implementation of such a process would, indeed, be one of the first steps in the deterioration of the Veterans Administration.

Again, thank you for the opportunity which you have given to me to express the opinion of the Disabled American Veterans on this subject. Please feel free to contact me if I can provide any additional information.

PREPARED STATEMENT OF ROY L. MITCHELL, ADJUTANT, COTTONDALE CHAPTER 80,
DISABLED AMERICAN VETERANS

Mr. Chairman and members of the subcommittee: On behalf of the more than 200 members of Cottondale Chapter No. 80 of the Disabled American Veterans I wish to thank you for your invitation to appear here today to present our views on the VA health and medical care programs. I am Roy L. Mitchell, Chapter Adjutant of Cottondale DAV Chapter No. 80 and a Past Department Commander of the DAV Department of Alabama.

Mr. Chairman, I would like to address the issue of VA health care provided to veterans in terms of the impact fiscal constraints have had upon the VA medical care system.

As you know, Mr. Chairman, the VA Central Office reports that nationwide VA staff to patient ratios for inpatient care are approximately 2.11 to 1. This figure is about one half the staffing provided in the private sector. The 2.11 to 1 ratio represents a goal that VA Central Office seeks to achieve and is an average of all of VA's medical facilities.

Quite frankly, I believe the severe fiscal constraint imposed upon the VA is directly responsible for this low staff to patient ratio. I simply cannot understand the rationale behind VA's policy that mandates personnel reductions accompanied by loss of beds to the system. At least, if beds must be cut, the employees could be redistributed elsewhere in the system to help alleviate shortages.

It would seem wise to me, that rather than cut acute health care beds, the VA should be converting them into nursing home care beds to handle the increasing demand for this type of care. To me, this would be more prudent than building new nursing home care facilities.

It seems almost sarcastic to ask, Mr. Chairman—what do you think will happen to VA facilities if the trend to cut personnel and resources is allowed to continue while there is an ever increasing demand on the system? The fact is, Mr. Chairman, if the VA cannot meet its current workload—what will we do with our rapidly aging veterans population in the next few years?

Mr. Chairman, there are two other points I wish to discuss which are of great concern to veterans. The first deals with the regulations the VA has proposed to restrict VA hospital care to nonservice-connected veterans who have incomes in excess of \$15,000 per year.

From my perspective, I believe this figure is by far too low, if such a means test is to be applied to VA health care, and should be set much higher. Any reasonable person should realize that an income of \$15,000 per year (in and of itself) is not sufficient to offset the exorbitant cost of private hospitalization.

For example, Mr. Chairman, if a veteran with an annual income of \$15,000 per year is denied admission to a VA hospital, but has no private insurance coverage, and is subsequently admitted to a private hospital and undergoes surgery for a gastric ulcer, that veteran will undoubtedly have medical expenses in excess of

\$3,000. This veteran will then be subjected to a severe financial hardship when you consider the high costs of living expenses coupled with the fact that 20 or more percent of his annual income must go toward paying his medical bills.

I ask, Mr. Chairman, is this the way a grateful nation treats its veterans? Personally, I would hope not.

The other point I wish to address deals with the contracting out of VA services as required by OMB Circular A-76. I believe that the contracting out of certain hospital services will result in fragmented and totally ineffective management of the VA's hospitals and outpatient clinics. But even more importantly, I believe that such contracting out will lead to substantial deterioration of the quality of VA health care provided to veterans. I would urge this distinguished Subcommittee to do everything possible to exempt the VA's Department of Medicine and Surgery from the provisions of OMB Circular A-76.

Mr. Chairman, I do want to express to you that I understand the severe fiscal restraint that has been placed upon all federal agencies and departments. However, spending in the area of veterans' programs over the past 5 years has declined in terms of the percentage of the federal budget from a high of 5.1 percent then, to 3.5 percent of all spending today. Additionally, the number of VA medical, surgical and psychiatric operating beds have been reduced by nearly 11,000 since June 30, 1976. The funds appropriated to the VA have assisted millions of veterans and their families and, in terms of breakthroughs and research, have benefited all Americans. Still, for many veterans, the VA remains their only source of health care and for others, such as Vietnam veterans, we simply hope that the system will be there when they need it.

That concludes my statement, Mr. Chairman, and I again wish to thank you for giving me this opportunity to express my views on these very important matters.

PREPARED STATEMENT OF KENNETH D. GOFF, SENIOR VICE COMMANDER, DISABLED AMERICAN VETERANS

In response to your letter dated October 6, 1981 in regard to Public Law 96-330 and circular A-76. I state the following.

A short while ago when a veteran approached the Veterans Administration for assistance with a service connected condition the veteran was treated as if he was a second class citizen. This was in the era when it wasn't popular to be a veteran. Through laws, personnel education and training, now when you go to the V.A. you are at least treated as a person and not just tolerated as in the past. At one time a vet had to be 100 percent disabled, total and permanent, to receive all medical care. Now 50 percent and above have this service available on all medical levels. Less than 50 percent receive medication and care for only the service connected condition and related conditions. Did not the whole man perform to receive the S.C. disability? If he did, why not treat the whole man? Any and all veterans whether disabled or not should receive the gratitude of their country for services rendered. I state this to show you I remember when.

If, and I hope you never contract out services at any V.A. hospital and you do, services will be a lesser service than the veteran now receives. Why? Because a house keeper will make only the rounds they are contracted to do, and what happens after he has made his rounds and someone spills a coke in the lobby or as in the case of Tuscaloosa V.A. being a mental hospital. A patient voids in the lobby, does it remain to offend all till the next round of the contract employee. If you have "standby personnel" to take care of all problems you will spend more than is presently spent.

Food services goes up for bids! Last year (hypothetically) you spent \$900,000.00 to feed, maintain, food services and you open for bids, some large fast food chain would be glad to lose \$100,000.00 the first year on a contract to get the equipment and paraphernalia in the V.A. kitchen (in Tuscaloosa this would be new because they are now renovating food services). Turned over to them plus, receive the umbrella of purchasing for the V.A. which I assume would be tax free. Who is to say where the 100 percent beef hamburger meat went to the V.A. or the chain restaurant? The next year after you have lost control, the bid could double. Where are you then? The food services for patients at the Tuscaloosa V.A. and I assume all V.A. hospitals can't be improved upon, because the dietetic department takes the greatest pride in the food and services to patients that anyone, or company could provide.

You have a consolidated laundry service owned and operated by the V.A. Do you kid yourself and think you can hire someone to do a job for you cheaper than you yourself can do it? (check the law suit of the V.A. versus the contract laundry services the V.A. had to take back).

If the V.A. can and does do such poor job of management why did the V.A. build a nursing home on the premises of the V.A. Tuscaloosa and 4 others the same size over the south at other V.A. installations? Why not send all patients to private nursing homes? You didn't because you can keep more patients in better facilities cheaper than in the private sector.

If the V.A. system employs the contract system they will generate retirement of many employees who will simply not want to leave the V.A. employment, (at least 40 percent of all local V.A. employees have over 20 years). The millions of dollars spent in placing Vietnam vets in the V.A. system will be wasted. In some job classifications such as house-keeping the Vietnam veterans make up 75.6 percent of this dept. You are increasing help to some Vietnam vets. And now you are wanting to jeopardize their jobs. The person whom you have hired as a high-level with a masters or PH. D. received this while the Vietnam vet was away at war. The Vietnam vet is a GS-3 or 4, while the person who evaded induction in military is a GS-11 or some such good paying job, who is the loser?

You wonder why you can't recruit Drs. and nurses and skilled personnel. Some of the reasons are you will not allow a doctor who desires to treat the whole patient the opportunity to do so and if he does he is constantly reminded that he has a quota and only so much time to see a patient. Each job of the skilled personnel has more people scrutinizing them than hours in the day. Soon the doctor that is recruited will be looking at other places and soon have V.A. doctors of a lesser quality, or of a foreign origin that the veteran can't communicate with because of language barrier and ethnic background. So complaints roll in and this doctor is promoted to a level where he is administrative and doesn't have to see veteran patients and it is rumored in the veteran circle "he was fired." His replacement, now hired by him, understand each other well, so he is hired, and the cycle is repeated.

The nurses are overworked and under-paid and are never allowed to interject into personnel quotas of patients to nurse ratio such as in nursing home, 1.7 patients to each nurse in V.A. nursing home, Tuscaloosa (3 shifts). If I was a nurse under these conditions, yes I would want to transfer to another unit with less work and the same pay, or leave V.A. employment and got to the private sector.

The V.A. employee can't strike! What about all employees of contract firms in all facets will not be under the no strike control, and the "laundry workers of America" strikes and all other unions honor the picket lines and refuse to cross, who will feed and see to the needs of the old and indigent and mental and physically sick patient?

The issue is politics and bureaucracy, not money versus patient care as you would like for us to believe.

I hope I never live to see the veterans of this nation denied any and all rights due them. Where was the war baby or unborn child? When Pearl Harbor was bombed or Iwo was taken and Gen. Doolittle bombed Tokyo, he was yet unborn or too young to take a hand. Every person under 40 years old owes his or her life to these men and women. If it was not for the courage and love of freedom of these and all others before and after, that put their lives and well-being only second to freedom and all human rights that they had, this country would have ceased to exist as a free country. These are the veterans you are denying services to.

What if we have another war, who will be the fodder to the cannon? Not the leaders of our country, no, the poor citizen who will be conscripted or will they as some of the bureaucratic leaders who now hold high positions in government, suddenly get religion or move to a bordering country as in the Vietnam conflict, and when it is over, receive amnesty and return and be placed at a very high level in our government.

If you must economize, start at the top. Vote all people in U.S. Government employ as well as elected, a wage reduction of substantial size starting with the President and reduce his and all other past Presidents' income from the U.S. Treasury to a good living, not as it is now a lavish sum of more than 100 poor people on a poverty level receive each month.

And only then will I concede we the veteran needs to tighten our belt, but only at the pro-rated scale equal to all alike. Did the Senate and Congress just get a raise voted in by them? We the veterans only have one vote each, and can't vote on our pay raises, but we can vote, come election time, we remember.

I do not in any way approve of budget circular A-76 and any other directives and or bills attached there-to.

I approve of Public Law 96-330 as stated.

PREPARED STATEMENT OF DON REED, TEAM LEADER, VET CENTER, BIRMINGHAM, ALA.

It is my pleasure to testify before this committee and all those present concerning the issues that presently face the Vietnam veteran and his/her family on our committee, and about the Vet Center Program (P.L. 96-22). As time goes on our issues seem to become larger and in need of more direct action.

Viet Nam has now been an active part of my life for over 15 years. It has been a burning issue of great national importance to me as a U.S. Army Captain, a Vietnam veteran's advocate, Director of a Vet Center Program, and as a U.S. citizen. After all of these years I have a better feeling than I have ever had before about America's willingness to look at the Viet Nam experience through the eyes of Vietnam veterans and to hear it as we hear it every day in the Vet Center. By being an open and comfortable place, the Vet Center serves as a listening post on the front lines hearing the stories of Vietnam veterans that no one else wants to hear; it also serves this country by being a national repository for some of this country's greatest current history as told by some of its finest warriors and citizens.

The personnel who comprise the Birmingham team are all highly qualified and individually quite motivated in their positions. At this time I would like to list the team's make-up.

Sally Springrose is our secretary/clerical person who additionally handles all client and agency scheduling. She initially screens clientele who come in for the first time. She is in charge of maintaining all files in the Vet Center; she has represented the Vet Center as our Purchasing Agent and was greatly responsible for procuring all of the appropriate material needed to open and maintain the Center. Sally has been the initial organizer and coordinator of the Women's Counseling Program now ongoing within the Vet Center. She is a white female, and has ten years' experience working with Vietnam veterans through the VA Medical Center in Birmingham and the Vet Center.

Donald Parker counsels on an as-needed basis with clients who come in off the street or call on the telephone. He specifically handles areas concerning employment, vocational and educational counseling, and veterans benefits. Time has also proven Don to be an excellent emergency and crisis counselor. Also, he has been involved in the community networking process with other agencies. Donald is a black male, a Vietnam veteran, and has eight years working as a counselor to Vietnam-era veterans in both government and private agency positions.

Tom Ashby manages the ongoing training at our Vet Center and provides training for new personnel and for personnel who are to be trained specifically as rap group facilitators. In the area of training, Tom also is the Regional Librarian for training materials in the Southeast and a member of the national training faculty. Tom coordinates assistance and referral concerning discharge upgrading cases; he is regionally responsible for disseminating and clarifying information that arrives through various channels concerning Agent Orange. Tom is a white male, Vietnam veteran, who has been actively involved in Vietnam Veterans Against War in Tuscaloosa, Ala. to later involvement at the local, state, and national level with other Vietnam-era veteran organizations, and as a discharge upgrading specialist for Legal Services Corporation.

As Team Leader, I serve counseling functions in all the areas mentioned above. I serve in a supervisory capacity over all of the areas mentioned in relation to each team member. Additionally, I serve special functions in the area of public relations and public sensitivity toward Vietnam veterans through the media. I provide most of the in-service training programs and public presentations. Additionally, I serve on the Regional Resources Group and national training faculty for Operation Outreach.

The primary services offered through the Vet Center at this time are counseling, oriented at the individual, group, and family level. There are currently three (3) Vietnam veteran rap groups functioning at the Center. One is an "open group", made up of people who have not previously been involved in a group experience. There is a constant change in the number of veterans who come to this group. The make-up varies greatly from week to week. As an individual progresses in this group, a new group is formed around targeted individuals who are screened out of the initial open group and placed in a second group, which deals with needs assessment. In this group the process and techniques of self-evaluation and needs-evaluation are established and dealt with through the group process.

The third group is the "growth group" for people who are not experiencing severe or traumatic problems and are seeking the group model as a support system for continuing a stable life.

The fourth group is a women's group which is primarily composed of wives, mothers, and girlfriends of veterans who are clients at the Vet Center. The women's group is run by Dr. Patty Jolly, of the VA Day Hospital Program, and facilitated by Sally Springrose, from our Center, who has been involved in in-house training from the counselors of the Vet Center in preparation of this role.

Out of the 1,000-plus veterans whom we have current and accurate files on, the racial background is approximately 50 percent white and 50 percent "minorities". This same percentage holds true for combat and non-combat status. Approximately 80 percent of the combat veterans we see are either seeking or needing readjustment counseling. Approximately one-third of the veterans who come to the Center have been seeking employment assistance or vocational and educational assistance toward employment goals. Most of the clients heard about the program directly through public relations efforts. Approximately 25 percent of our clients are referred from other agencies.

One interesting note is approximately one-third of the initial contacts with our male veterans has been made by female acquaintances. This has led to a considerable amount of family counseling and the family being involved, in general, with resolving various problems for the individual veteran. We have found that family support systems like this are greatly beneficial to our clientele. Auxilliary support from other community service agencies has been successful on a referral basis. Internal referral sources within the VA system have also worked well.

The latter case is due to efforts by Mr. Hugh R. Vickerstaff, Director, VAMC, Birmingham, and Dr. Robert Slaughter, Chief of Staff, VAMC, Birmingham. They have been more than helpful in opening all avenues of support through their staffs and their past expertise. Also Dr. Jesse Milby, Chief of Psychology, VAMC, Birmingham, and Administrative Liaison to the Vet Center, has been of tremendous value as a supportive referral source, particularly in cases which were out of the purview of the Vet Center counseling format. The success of these kinds of networking functions has been greatly enhanced by cooperative in-service training programs.

In the area of successes, our greatest are probably in those intangible areas where peoples lives, over a course of time and contact, somehow are improved in an emotional manner demonstrably different from their past existence. Secondly, I feel that the program's existence has been of value in improving the Vietnam-era veterans image in the local community. Many times publicity is oriented toward Vietnam veterans with dramatic problems. We have had our share of this, particularly in crisis intervention situations; however, we have also been well blessed with a great response from the well adjusted Vietnam-era veterans who make themselves available to assist their fellow veterans. This is most noticeably evident in the support given to veterans by each other in rap groups and in the make-up of the advisory board for the Birmingham Vet Center. This board is comprised of Vietnam veterans of varied and successful backgrounds, as well as other interested citizens, who have the needed skills and ability to offer advice and guidance. This model of social self-help is certainly most cost efficient.

I feel that the successes of our program in Birmingham could be pursued at length. An analysis of our program in relation to direct veteran services, inter-agency cooperation, or through the eyes of the Vietnam veterans would rate well.

We also are aware that there are many issues facing Vietnam veterans that we are not fully prepared to resolve. The issue of Agent Orange still looms as a nemesis because little is known; however, all services are being rendered in regard to this issue, through the VA Medical Center in Birmingham in accordance with regulations, i.e. screening is being done for all clientele who suspect a possible exposure to Agent Orange.

A similar situation exists with the discharge upgrading problem. We are now seeing veterans with less than honorable discharges for counseling and referral. This does not, however, answer the counseling problem presented to a veteran with a less than honorable discharge when this barrier in itself is a major portion of his readjustment problems. Ultimately we have not answered the question of arbitrary administrative "branding" of personnel during an era of tremendous social turmoil and social conflict. The process of discharge upgrading can be long and arduous and in itself provides increasing frustrations, psychologically, to the veteran involved. I feel that the Vet Center personnel should facilitate the upgrading process in conjunction with other supporting agencies, especially if more specific training were done in this area and more clear guidelines were allowed in the direct participation of this process by the Vet Center personnel.

The unique design of the Vet Center Program allows it to develop its direction through the interpretation of needs on an individual contact basis; therefore, training and continual resource development are essential in the management of a Vet Center. Effecting program change toward individual recipient needs at this level

requires constant evaluation and creative management. For instance, we, in Birmingham, are continually uncovering a deep need for help and understanding in the area of spiritual needs; therefore, we have developed a local religious needs resource group to study this problem/need and help develop better therapy approaches in dealing with this situation. Pursuant to this situation, I have enlisted the assistance of Patrick Green, Ph.D., Chairman, Religious Studies Department, University of Alabama, and Rev. Louis Wilhite, of Birmingham, Ala.

In addressing the special needs of Vietnam-era veterans it becomes quite obvious that in order for us to fully "come home", that coordination and integration of effort and concern from many factions of our society are needed to make a Vet Center Program completely holistic and therefore be able to serve as a nucleus for America to also "come home" to us. For that to become a national reality we must have great support at state and local government levels and a positive effort from the public at large to understand the needs of these people and the debt that is outstanding in their behalf. This is a delicate and time consuming effort; and we at the Birmingham Vet Center are thusfar pleased with our efforts after two years in operation, but more is left to be done.

Just as the need for this program was here at least a decade before its conception, some of the needs of the people that this program serves will still be there after the life of this program. This makes one of the most important missions of this program to integrate the service of these needs into existing state and local government and privately developed community based organizations, such as Alabama Veterans Services, Inc.

The parades and the welcome home that were not present for so many years for Vietnam-era veterans will not now help heal the wounds that their absence exacerbated. Services to those in need and understanding by those who serve are of first order.

Vietnam veterans fought the longest war in our nations history, and we are the only armed force ever deployed by this country who were never defeated in a major battle. Let us give no less in our service to these special people than they gave us in their service.

PREPARED STATEMENT OF CHARLES E. PENDLETON, PRESIDENT, LOCAL 131,
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. Chairman, my name is Charles E. Pendleton, and I am President of Local 131 of the American Federation of Government Employees, representing all the employees at Veterans Administration Medical Center at Tuscaloosa, Ala., except for supervisors, management and registered nurses

I appreciate the opportunity to present testimony before this subcommittee.

Having been an employee of V.A. for some 20 years, I have seen many changes, most of these changes were for the better. Now we are faced with the most dreaded change of all, contracting-out, under O.M.B. A-76.

To keep it strictly on a local basis, this station has had numerous problems with contractors of a construction nature. When our nursing home was built, almost immediately the roof had to be repaired. A contract was let to change this nursing home air conditioning system, all this at additional cost. This station had a default by a contractor that held up a kitchen remodeling project for approximately two years. These same contractors are then awarded other Federal contracts. The reason for this is, that there are not sufficient control at the local level. What control there is becomes so complicated that the attitude is, oh whats the use. Another area where present contractors are a problem is in uniform procurement, for those employees required to wear government issued uniforms. Some companies continuously put out substandard products. The recall procedures on these products are so weighed in favor of the contractor that it can take years to correct. I use these examples only to show that there is no control of contracts even in non-vital areas. How then could these same type incidents be tolerated in critical patient care areas?

A draft prototype of a statement of work for V.A. food service was received by A.F.G.E. for comment. They were allowed 30 days. At the local level I was given 7 days. I could hardly read this document in that period of time. This statement of work is written to where the government furnishes everything, equipment down to pots, pans, and silverware, all facilities and anything else that is needed by the contractor, even to include the uniforms to be worn by contract employees. On the other side, the control of the contractor is very loose. Generally it states that quality assurance officer could take action if a 10 percent deviation occurred. I wonder does this mean that 10 percent of our veterans did not get fed. Can any of our disabled

patients be denied 100 percent effort? I believe they would be denied this under a contract.

The General Accounting Office investigated, at Congressional request and reported. "We found questionable cost comparison practices which influenced all 12 of the contracting-out decisions reviewed"—April 22, 1981.

Some years ago Congress passed a Veterans Readjustment Act, to give Veterans an incentive to come to work for V.A. Almost all the jobs in V.A. that are marked for contract are filled with these same veterans. True contractors are required to give preference to these veterans, but that is all; very low pay and no fringe benefits. This does not seem to me what Veterans Readjustment Act was intended to mean. At our station, of the jobs marked for contracting out . . . Dietetics 70 employees, 59 veterans and 40 of these are Vietnam; Building Management 45 employees, 44 veterans and 34 of these are Vietnam veterans; Laundry 31 employees, 22 veterans and 14 of these are Vietnam veterans; Building Maintenance 53 employees, 42 veterans and 15 of these are Vietnam. This breaks down to almost 85 percent of the jobs to be contracted, rightfully belong to that group of people that Veterans Administration and the country owes the most, our veterans. I have not been able to break down how many of these employees are service connected veterans, but I know it would be several. Even if they are not service connected, they deserve the same treatment for they have shown their willingness to put themselves in harms way for benefit of others.

As for the impact of budgetary restraints on hospital admitting practices. I personally feel that all service connected veterans should be treated for their service incurred disabilities, regardless of their so called percentage. Even non service connected veterans, who are truly not able to pay for their treatment, should be admitted on a bed available basis.

In regards to Public Law 96-330. I am not familiar enough with this law to make any meaningful testimony.

In summary it is my personal belief, if we affected people sit by and let V.A. be contracted-out, our livelihood will no longer exist. It matters not that we are dedicated career employees. The ability of V.A. to deliver quality health care will no longer exist. Therefore Veterans Administration as we know it today, will truly be dead.

[From the Federal Register, July 29, 1981]

VETERANS ADMINISTRATION

SCHEDULE OF REVIEWS FOR "CONTRACTING OUT"; INITIATIVE OF VETERANS ADMINISTRATION'S DEPARTMENT OF MEDICINE AND SURGERY

The public is hereby given notice of the Veterans Administration's (VA) intent to study certain commercial-industrial type activities (hereinafter called CITA's) of its Department of Medicine and Surgery (DM&S), in consonance with Office of Management and Budget (OMB) Circular A-76. This circular is the Government's general expression of its longstanding policy of not competing for business with citizens, and for relying on the private enterprise of our economy to furnish the goods and services the Government needs. Circular A-76 has been used to identify and schedule for critical cost review all the CITA's within jurisdiction of the Circular's rules while respecting the DM&S legal mandate to provide a complete hospital and medical service for the nation's veterans (see Title 38, United States Code).

The following CITA's are listed first alphabetically by State, then alphabetically by VA medical facilities within each State. Each CITA corresponds to a month during which a formal cost review shall be initiated by the facility which manages a particular CITA. Before or during the calendar month scheduled below (but not later than one month beyond the original date), a local VA contracting officer will post advertisement in the Commerce Business Daily, to ascertain bidder interest in contracting with the Government to perform the CITA concerned. Not later than the deadline provided in the CBD advertisement, two or more responsible business firms must indicate their interest in order for further review to proceed. If two or more potential bidders' interest is obtained, competitive bids will be solicited based upon the VA's specifications for the activity, called a statement of work (SOW), and upon normal government procurement procedures. Concurrently, with the same SOW, the VA will prepare an estimate of its present and projected costs to furnish the same CITA using government facilities, government equipment, government supplies and government employees. Formal bids received from interested firms will be compared against the Government's cost estimate in accordance with OMB's Cost

Comparison Handbook, "Supplement 1 to OMB Circular A-76." The decision to award a contract or to retain a CITA in house (with government employees, etc.) will be based on the economic analysis of each method's relative total cost to government. On completion of the cost comparison, but prior to an award decision being made, all information pertinent to the development of in-house costs, competitive bids, and the cost comparison procedure will be available for public inspection (normally 10 days) at the local facility. The first award decision will be reviewed in Washington, D.C. by the VA's Chief Medical Director (13) and Assistant Administrator for Supply Services (90).

Private firms winning contracts with the VA in this program must meet all requirements of the Service Contract Act (PL 89-286), including but not limited to, the requirement for paying certain minimum wage and salary rates to the contractor's employees, as established by surveys of the U.S. Department of Labor. Also, VA employees to be displaced by the award of a contract in this program must be offered a first-refusal opportunity for private employment with the contractor (in job for which they qualify).

Should it become necessary to substantially change this schedule of reviews in the future, appropriate notice shall be posted herein.

Questions relating to the schedule of reviews for the Department of Medicine and Surgery CITA's, or the "contracting out" policy in general may be directed to John M. Bradley at (202) 389-2007. Requests for single copies of the schedule should be made in writing only to: Assistant Chief Medical Director for Administration (13A1), Department of Medicine and Surgery, Veterans Administration, 810 Vermont Avenue, NW., Washington, DC 20420.

Questions relating to local matters about "contracting out" should be referred to the Director of the VA medical facility concerned. Single copies of OMB Circular A-76 and the Cost Comparison Handbook are available without charge from the Publication Division, OMB, 726 Jackson Place, NW, Washington, DC 20503.

Dated: July 21, 1981.

ROBERT P. NIMMO, *Administrator.*

CITA	Review date
State: Alabama VA Medical Center: Birmingham 35233	
Hospital Pharmaceutical Services:	
Mail-out Prescription Services.....	March 1982.
Pharmaceutical Pre-packaging Services.....	July 1982.
Hospital Plant Maintenance Services:	
Plumbing/Steamfitting Maintenance.....	November 1981.
Carpentry Maintenance.....	Do.
Electrical Maintenance.....	Do.
Masonry Maintenance.....	Do.
Painting.....	Do.
Air Conditioning/Refrigeration Maintenance.....	Do.
Grounds Maintenance and General Labor.....	Do.
Hospital Food Services: Food Preparation and Delivery Service.....	September 1982.
Hospital Administrative Services:	
Medical Transcription.....	September 1981.
Photocopy Services.....	November 1981.
Medical Records Processing, Storage, Retrieval, Maintenance.....	November 1982.
Clinic Appointment Scheduling.....	February 1983.
Hospital Supply Services: Storage and Distribution Services.....	September 1982.
Hospital Custodial Services:	
Environmental Sanitation.....	February 1982.
Hospital Media Services:	
Medical Library Services.....	December 1982.
Other Hospital Services:	
Keypunching Services.....	August 1981.
Chaplain Services.....	May 1982.

VA Medical Center: Montgomery 36109

Hospital Pharmaceutical Services:	
Mail-out Prescription Services.....	March 1982.
Pharmaceutical Pre-packaging Services.....	July 1982.
Hospital Plant Maintenance Services:	

CITA	Review date
Plumbing/Steamfitting Maintenance	November 1981.
Carpentry Maintenance	Do.
Electrical Maintenance	Do.
Masonry Maintenance	Do.
Painting	Do.
Air Conditioning/Refrigeration Maintenance	Do.
Grounds Maintenance and General Labor	Do.
Hospital Food Services: Food Preparation and Delivery Services	September 1982.
Hospital Administrative Services:	
Medical Transcription	September 1981.
Photocopy Services	November 1981.
Medical Records Processing, Storage, Retrieval, Maintenance	November 1982.
Clinic Appointment Scheduling	February 1983.
Hospital Supply Services: Storage and Distribution Services	September 1982.
Hospital Custodial Services: Environmental Sanitation	February 1982.
Hospital Media Services: Medical Library Services	December 1982.
Other Hospital Services:	
Keypunching Services	August 1981.
Chaplain Services	May 1982.

VA Medical Center: Tuscaloosa 35404

Hospital Pharmaceutical Services:	
Mail-out Prescription Services	July 1982.
Pharmaceutical Pre-packaging Services	July 1982.
Hospital Plant Maintenance Services:	
Plumbing/Steamfitting Maintenance	November 1981.
Carpentry Maintenance	Do.
Electrical Maintenance	Do.
Masonry Maintenance	Do.
Painting	Do.
Air Conditioning/Refrigeration Maintenance	Do.
Grounds Maintenance and General Labor	Do.
Hospital Food Services: Food Preparation and Delivery Services	September 1982.
Hospital Administrative Services:	
Medical Transcription	September 1981.
Photocopy Services	November 1981.
Medical Records Processing, Storage, Retrieval, Maintenance	November 1982.
Clinic Appointment Scheduling	February 1983.
Hospital Supply Services: Storage and Distribution Services	September 1982.
Hospital Custodial Services:	
Environmental Sanitation	February 1982.
Interior Design Services	March 1983.
Hospital Media Services:	
Still Photography	May 1982.
Photographical Laboratory Services	Do.
Reproduction/Duplication of AV Products	Do.
Sound Recording Services	Do.
Graphic Arts Services	Do.
Closed Circuit Television Services	Do.
Medical Library Services	December 1982.
Other Hospital Services:	
Keypunching Services	August 1981.
Chaplain Services	May 1982.
Laundry Services	July 1983.

VA Medical Center: Tuskegee 36083

Hospital Pharmaceutical Services:	
Mail-out Prescription Services	February 1982.
Pharmaceutical Pre-packaging Services	July 1982.
Hospital Plant Maintenance Services:	
Plumbing/Steamfitting Maintenance	November 1981.
Carpentry Maintenance	Do.
Electrical Maintenance	Do.
Masonry Maintenance	Do.
Painting	Do.

CITA

Review date

Air Conditioning/Refrigeration Maintenance	Do.
Grounds Maintenance and General Labor	Do.
Hospital Food Services: Food Preparation and Delivery Services	September 1982.
Hospital Administrative Services:	
Medical Transcription	September 1981.
Photocopy Services	November 1981.
Medical Records Processing, Storage, Retrieval, Maintenance	November 1982.
Clinic Appointment Scheduling	February 1983.
Hospital Supply Services: Storage and Distribution Services	September 1982.
Hospital Custodial Services:	
Environmental Sanitation	February 1982.
Interior Design Services	February 1982.
Hospital Media Services:	
Still Photography	May 1982.
Photographical Laboratory Services	Do.
Medical Library Services	December 1982.
Other Hospital Services:	
Keypunching Services	August 1981.
Chaplain Services	May 1982.
Laundry Services	July 1982.